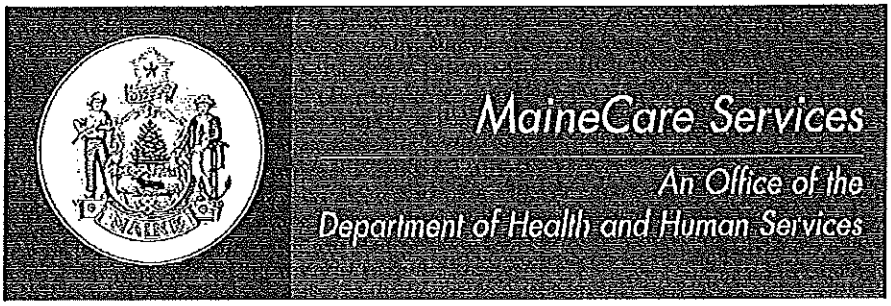


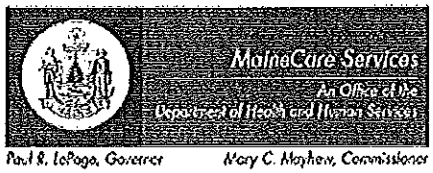
Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

Title:

Maine Medicaid Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS

Number:

11-W-00128/1



Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-2674; Fax: (207) 287-2675
TTY Users: Dial 711 (Maine Relay)

June 25, 2013

Wakina Scott, PhD
Project Officer
Division of State Demonstrations & Waivers
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Mailstop S2-01-16, 7500 Security Blvd., Baltimore, MD 21244

Dear Ms. Scott,

By this letter, Maine requests the Centers for Medicare and Medicaid Services (CMS) to renew its Maine Medicaid Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS under the Social Security Act, effective January 1, 2014. This Waiver currently provides coverage for 421 enrollees and to date has not instituted a wait list.

Maine will demonstrate that it complied with the Special Terms and Conditions (STCs), including budget neutrality requirements and reporting.

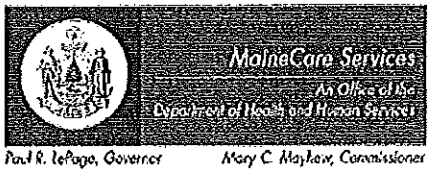
Maine does not anticipate asking for any substantial modifications to the existing Demonstration. Attached to this letter is a report summarizing compliance with the STCs and budget neutrality requirements.

We look forward to working with you during the application process. If you have any questions, please contact Stefanie Nadeau at Stefanie.Nadeau@maine.gov or 207-287-2093.

Sincerely,

Stefanie Nadeau

Stefanie Nadeau, Director
MaineCare Services



Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-2674; Fax: (207) 287-2675
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December 24, 2012

Ms. Victoria Wachino, Director
Division of State Demonstrations and Waivers
Center for Medicaid, CHIP and Survey and Certification, CMS
Mailstop S2-02-26, 7500 Security Blvd., Baltimore, MD 21244

Dear Ms. Wachino,

We are writing in accord with a CMS letter dated November 29, 2012 which provides guidance on section 1115 demonstration projects which expire December 31, 2013. We appreciate CMS's flexibility giving states additional time to submit waiver extensions documentation.

This letter serves as a request to extend the date by which Maine must submit its HIV/AIDS Section 1115 Demonstration Waiver (11-W-00128/1) to June 30, 2013. Maine will provide all documentation required to meet federal standards, including the elements outlined in section 431.412(c).

Maine understands the importance of providing CMS with documentation necessary to demonstrate transparency and the financial and qualitative effectiveness of the Waiver. We are committed to meeting these requirements and providing timely and high quality information for CMS review and approval for the HIV waiver to be extended.

We look forward to working with our CMS partners to meet reporting and quality requirements as we work toward implementing a full HIV Waiver extension. If you have any questions, please contact Dr. Kevin Flanigan at Kevin.Flanigan@maine.gov.

Sincerely,

Stefanie Nadeau, Director

MaineCare Services
11 State House Station, Augusta, ME 04333-0011
Phone: 207-287-2093

Cc: Dr. Kevin Flannigan, OMS

Cindy Mann, CMCS

Angela Garner, CMCS

Rich McGreal, CMS Regional Office

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Introduction

The MaineCare HIV/AIDS 1115 Demonstration Waiver began in July 2002. The waiver has been renewed twice; once in 2007 and once in 2010. The goal of the Waiver is to provide more effective and earlier treatment to prevent, reverse, or delay disease progression. The Demonstration includes two populations: enrollees who are living with HIV/AIDS and have incomes at or below 250% of the Federal Poverty Level (FPL) and Medicaid/MaineCare members who live with HIV/AIDS and have incomes at or below 100% FPL.

Maine is anticipating a final decision from the Administration regarding the possibility of the addition of a new Medicaid expansion population in January 2014 as allowed by the Affordable Care Act. Information about this population can be found in the attachment titled 'Transition Plan'.

This report accompanies Maine's letter requesting a renewal of the Maine Medicaid Section1115 Health Care Reform Demonstration for Individuals with HIV/AIDS. Much of this report summarizes the activities of the tenth year of the Demonstration (SFY12), and is representative of the effort throughout the Waiver's history.

Enrollment

At the conclusion of the tenth year, there were four hundred seventeen (417) demonstration enrollees and one hundred ninety five (195) Medicaid members enrolled in the program. Below is a summary of enrollment over the ten years of the project by month. There has been an increase of three hundred thirty two (332) demonstration enrollees and a decrease of thirty three (33) Medicaid members from the first month of SFY2003 to the last month of SFY2012. The algorithm that determines Medicaid members was changed in SFY2012 resulting in a drop in the Medicaid population.

Table 1

Special Benefit Waiver Demonstration Project

Count of Members by Group at the End of Each Month

Month	Demonstration Enrollees	Medicaid Members	Total	Demonstration Enrollees	Medicaid Members	Total	Demonstration Enrollees	Medicaid Members	Total
	SFY 2003			SFY 2004			SFY 2005		
July	85	228	313	124	280	404	143	301	444
August	94	226	320	125	277	402	141	300	441
September	97	224	321	131	273	404	140	297	437
October	94	244	338	132	292	424	143	298	441
November	94	244	338	134	286	420	146	295	441
December	98	241	339	134	286	420	146	296	442
January	102	258	360	134	295	429	156	305	461
February	108	256	364	140	292	432	160	301	461
March	113	253	366	143	288	431	163	297	460
April	117	264	381	144	288	432	174	308	482
May	119	265	384	142	291	433	179	302	481
June	123	263	386	140	290	430	181	298	479

Month	Demonstration Enrollees	Medicaid Members	Total	Demonstration Enrollees	Medicaid Members	Total	Demonstration Enrollees	Medicaid Members	Total
	SFY 2006			SFY 2007			SFY 2008		
July	191	309	500	272	305	577	293	275	568
August	207	303	510	273	301	574	291	273	564
September	213	301	514	277	300	577	281	269	550
October	224	295	519	292	289	581	284	272	556
November	228	287	515	292	288	580	283	270	553
December	239	280	519	291	285	576	283	267	550
January	248	291	539	298	281	579	289	256	545
February	256	287	543	301	276	577	291	257	548
March	256	283	539	292	276	568	287	262	549
April	263	297	560	298	274	572	288	267	555
May	261	296	557	292	274	566	295	265	560
June	264	292	556	282	274	556	295	263	558

Month	Demonstration Enrollees	Medicaid Members	Total	Demonstration Enrollees	Medicaid Members	Total	Demonstration Enrollees	Medicaid Members	Total
	SFY 2009			SFY 2010			SFY 2011		
July	286	269	555	331	283	614	382	307	689
August	276	272	548	332	280	612	386	308	694

September	283	269	552	333	281	614	363	295	658
October	288	270	558	337	284	621	371	289	660
November	289	275	564	339	286	625	379	294	673
December	296	282	578	346	290	636	395	288	683
January	300	284	584	348	296	644	396	289	685
February	302	288	590	349	298	647	399	281	680
March	312	290	602	350	301	651	407	289	696
April	315	288	603	355	300	655	413	298	711
May	316	284	600	369	301	670	413	296	709
June	323	280	603	381	313	694	415	290	705

Month	Demonstration Enrollees	Medicaid Members	Total
	SFY 2012		
July	416	292	708
August	417	284	701
September	417	284	701
October	420	291	711
November	428	286	714
December	423	283	706
January	414	248	662
February	420	242	662
March	413	177	590
April	419	183	602
May	417	187	604
June	417	195	612

Out of the four hundred seventeen (417) demonstration enrollees enrolled at the end of SFY2012, three hundred seventy (370) were male and forty seven (47) were female. Out of the one hundred ninety five (195) Medicaid members enrolled at the end of SFY2012, one hundred thirty (130) were male and sixty five (65) were female. A breakdown of gender and age by month shows an increase of two hundred ninety three (293) demonstration enrollee males from the beginning of the demonstration project in SFY2003 to the end of SFY2012, while the number of women increased by thirty nine (39). In the Medicaid population, there was a decrease of thirty (30) males and a decrease of three (3) females.

Distinct member counts by quarter show that one hundred twenty seven (127) of the one hundred thirty two (132) cohort members were enrolled in the last quarter of SFY2012. Of these, one hundred fifteen (115) members were included in the Medicaid group and twelve (12) members were moved to the Demonstration group.

Demonstration Cost Neutrality Cap

The Section 1115 HIV/AIDS Demonstration Waiver consists of two groups: 1) "Members" who are MaineCare members identified as HIV-positive with their HIV costs being at least 25% of the total costs of care; and 2) "Enrollees" who do not meet the eligibility requirements of MaineCare, but who are HIV positive and at or below 250% of the Federal Poverty Level.[1]

When the State applied for the HIV Waiver in 2001, we used a model called a Markov Process mathematical model, to demonstrate budget neutrality. This model, along with the resulting budget figures, was reviewed by CMS and the Office of Management and Budget, and approved by CMS. We used the same cost-neutrality model for the Waiver renewal application approved in 2007. This model is also used in the 2013 renewal request.

Richard D. Moore and colleagues at The Johns Hopkins School of Medicine developed a Markov Process model for HIV infection shortly before the introduction of Highly-Active Antiretroviral Therapy (HAART).[2] The model estimates rates of disease progression with various levels of healthcare, and moves an individual from state to state according to a set of disease-state-specific probabilities.

---

[1] Members receive all of the medically necessary covered MaineCare services, while enrollees receive a targeted essential set of MaineCare services that includes inpatient and outpatient hospital care, physician care, laboratory monitoring, psychiatric and substance abuse services, social service support, and prescription medications. Enrollees contribute for the cost of their care with co-payments for medicines and for physician visits, and monthly premiums for some enrollees.

[2] Moore, Richard D. and Chaisson, Richard E., "Costs to Medicaid of Advancing Immunosuppression in an Urban HIV-Infected Patient Population in Maryland", Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 14.3 (1997),

The State used the model and derivations of disease progression built into the model to estimate disease progression without antiretroviral therapy. We used information from medical literature and the experience of the Maine Medical Center Viral Treatment Center to estimate rates of disease progression with modern antiretroviral therapy. We then interpolated between the historic rate of disease progression without antiretroviral therapy and rates of disease progression with ideal antiretroviral therapy to estimate the effects of interruptions in antiretroviral therapy and lack of nurse-based care management.

The Markov Process model uses four disease states based on the patient's CD4 count:

Disease State	CD4 count
Asymptomatic HIV Infection	>350
Symptomatic HIV Infection	200-350
AIDS	< 200
Death	

We then developed two scenarios: a "With Waiver" scenario, and a "Without Waiver" scenario. We interpolated between the ideal treatment Markov Process model and the without antiretroviral therapy Markov Process model to estimate the effects of losing the Waiver on the loss of medical care, interruption or loss of antiretroviral therapy, and loss of care management. From this information, we developed an overall cost equation.

Budget Neutrality Equation

Total With-Waiver Demonstration Cost + Total With-Waiver MaineCare Cost

≤ Total Without-Waiver MaineCare Cost

Where

Total With-Waiver Demonstration Cost = ∑(Disease-State-Specific Demonstration Membership * Disease-State-Specific Cost Per Demonstration Member)

Total With-Waiver MaineCare Cost = ∑(Disease-State-Specific MaineCare Membership * Disease-State-Specific Cost Per MaineCare Member)

Total Without-Waiver MaineCare Cost = ∑(Disease-State-Specific MaineCare Membership * Disease-State-Specific Cost Per MaineCare Member)
We project that it will cost less to renew the Waiver than it would to end the Waiver. Specific cost data are included in the spreadsheets attached to this report.

Waiting List

The waiting list has not been utilized during SFY12 for this project, as the cost of patient care is not projected to exceed the project allotment. However, the State may institute a cap in the future should the budget estimates indicate costs will exceed the project allotment.

Applications

Applications for the waiver can be filled out in any of the Department of Health and Human Services' (DHHS) seventeen (17) regional offices or by case managers at the Ryan White case management agencies. Applications have also been sent to members' homes by the program coordinator or the eligibility workers in the local offices for members to fill out in the privacy of their own home. People enrolled in the AIDS Drug Assistance Program (ADAP) are sent letters explaining the demonstration project and encouraging them to apply.

Outreach

There were many outreach activities that occurred throughout the Waiver program. In SFY12, outreach activities included:

- Attended HIVAC meeting. Present were representatives from Ryan White Case Management Agencies, ADAP, Maine CDC, Office of MaineCare Services (OMS), legislators, people living with HIV/AIDS, and appointed committee members;
- Attended the monthly Ryan White meeting. People present were case managers, members, providers, and representatives from other various agencies;
- Attended weekly Decision Support System (DSS) User Group meetings to discuss the DSS and system issues, workarounds, and resolutions;
- Enrollment applications continue to be distributed to all DHHS offices, primary care provider offices, pharmacies, and hospitals in the State of Maine;
- Referred MaineCare members to ADAP staff for ADAP applications to cover the $10 co-pays for HIV and opportunistic infection drugs;
- Referred MaineCare members and case managers to eligible Medicare B buy-in programs;
- Referred members and case managers to Private Health Insurance Premium Benefit (PHIP) specialists;
- Worked with policy, provider relations, and customer service staff to resolve issues;
- Addressed Medicare Part D issues and referred members when appropriate;

- Sent out four hundred eight (480) birthday letters to members in SFY2012. Birthday letters encourage members to stay in good health by setting up their annual screenings (such as cervical exams, mammograms, and colon exams) and immunizations (such as the Influenza vaccine);

- Sent out introductory letter, PCP inquiry letter, and consent form to ninety five (95) new and re-joining members;

- Worked with non-categorical HIV MaineCare members encouraging them to switch eligibility to the HIV waiver program;

- Gave instructions to providers and case managers on how to use our website to access the HIV brochure, the MaineCare Preferred Drug List, and the MaineCare Benefits Manual;

- Worked with the Ryan White Case Management Agencies to communicate information regarding the transportation initiative and stakeholder meetings that members could attend;

- Worked with Maine CDC HIV, STD and Viral Hepatitis Program Director to forward emails to our provider distribution list about a survey that examines the state of HIV care in primary care settings. This study assisted with identifying obstacles and opportunities in primary care for prevention and treatment of HIV.

- Attended a webinar: Understanding the Maine Pre-existing Condition Insurance Program;

- Program Coordinator attended Health Coverage Central Workshop. Items discussed included:

- How to describe and screen for potential eligibility for MaineCare coverage and how to assist with the application and appeal processes;

- How to describe and screen for potential eligibility for non-insurance health care options, including hospital free and sliding-scale care, free and sliding-scale health and dental clinics, prescription assistance programs and the Medicare Savings Program (MSP);

- How to describe and screen for potential eligibility for DHA programs including DirigoChoice, the Pre-existing Condition Insurance Plan (PCIP), HCTC and the Part-Time and Seasonal Worker Voucher program; and,

- How to assist someone with the complex task of comparing different insurance policies and describing basic insurance protections, including how to appeal a claim or authorization denial in Maine.

- Met with the Office of Substance Abuse and Mental Health Services (SAMHS) to discuss how to engage clients with Behavioral Health issues. Present were various stakeholders from SAMHS. Future collaboration and trainings will be scheduled;

- Met with the new AIDS Drug Assistance Program (ADAP) Coordinator to discuss the Waiver program, processes, and collaboration efforts;

- Met with Molina, Thomson, and State staff to discuss changes needed to the DSS care management reports, letters, and the algorithm;

- Met with the AIDS Education and Training Center to discuss the 2010 provider survey results and ideas for future trainings and future collaboration efforts; scheduled follow up meeting and discussed a training/webinar in the spring for PCPs;

- Nurse Coordinator attended HIV, STD & Viral Hepatitis Integrated Conference. This was a two-day conference that included a panel discussion and presentations on HIV and aging, pain management, prevention with positives, and an "ask the expert" panel. On the second day, sessions attended included Hepatitis B and C, Syphilis in Maine, sexual health and aging, and the integration and change of different perspectives of HIV, STD, and Viral Hepatitis efforts in Maine. MaineCare had a booth set up on the second day with Waiver and educational materials.

- Mailed the semi-annual clinical data collection letter to Infectious Disease specialists;

- Collaborated with the CDC to mail out the 2011 annual member satisfaction survey. The survey was sent to seven hundred forty nine (749) members. We received a fifty four percent (54%) response rate which was a six percent (6%) increase from 2010. Four hundred seventeen (417) follow-up calls were made to members who expressed issues or concerns on their surveys.

- Nurse Coordinator attended the Annual Infectious Disease conference. Topics discussed included the history of Infectious Disease and Epidemiology, the impact of HealthCare Associated Infections between acute and long term care facilities, the interface of animal and human health, the Syphillis outbreak in New Brunswick, and a short presentation on HIT and its uses, especially in tracking Infectious Disease. Case studies were also presented. MaineCare had a table set up with Waiver and educational materials.

- Met with the CDC, ADAP, and Positive Health Care to discuss programs, collaboration efforts, funding, and formularies;

- Sent the fall poster and brochure mailing to high schools and universities. Mailing was distributed to approximately one hundred fifty (150) sites.

- Sent monthly informational letters and medication alerts to our Primary Care Provider Network. Medication alerts covered topics such as: revisions made to the Norvir label, prescribing information concerning interactions between protease inhibitors and certain statin drugs, drug interactions between Victrelis (boceprevir) and certain boosted HIV protease inhibitor drugs, Viread label and drug interactions between the Hepatitis C virus (HCV) protease inhibitor Victrelis and certain HIV protease inhibitors (atazanavir, lopinavir, darunavir), approved guidelines for the expansion of the use of Raltegravir (Isentress) to treat HIV infection in children and adolescents, and revisions to the dosing of Sustiva (efavirenz) for certain patients if it is co-administered with rifampinto. Alerts were typically sent to approximately two hundred thirty (230) providers.

- Met with State staff, Thomson and Molina to work on HIV Decision Support System (DSS) reports. One discussion that took place was the need to revise the current algorithm as it is in the DSS. The algorithm should be revised to eliminate the drug reference/requirement. As Hepatitis treatments have changed over the years, changes need to be made to the algorithm to avoid pulling in non-HIV infected individuals. The new algorithm would be: Two service claims (within a year) with a HIV/AIDS diagnoses AND 25% of the members total costs are HIV related. Another item discussed included the historical eligibility reports we need from Molina to re-send the draft reports that have been sent to CMS. DSS does not hold historical eligibility. For example a member who may have been on the Waiver back in October 2010 and was later transitioned to full MaineCare retroactively would now only show full MaineCare coverage in October 2010, and not the Waiver coverage they actually once had.

- The Nurse Coordinator viewed a webinar, which focused on the aging population living with HIV/AIDS. There were presentations by five different professionals across the country. It is predicted that by 2015, fifty percent (50%) of the HIV/AIDS

population will be over fifty (50) years old. The Area Agencies on Aging, Health Resources & Services Administration, AIDS Education and Training Center, and www.AIDS.Gov are developing new ways for getting information out to the older adult population.

- Sent the 2011 Provider Survey to two hundred forty seven (247) providers including both Primary Care Providers and Infectious Disease Specialists. The 2010 analysis was also included with the survey.

- Completed second 2011 Provider Survey mailing. The survey was sent to providers who didn't send a survey back after the first mailing. Second mailing went to one hundred eighty two (182) providers.

- Nurse Coordinator attended a two day conference: 'Emerging Issues in the HIV Patient: A Faculty Development Program'. Topics at this conference included: Treatment Update, Primary Care and Long Term Complications, HIV/HCV-Nutrition for Life, CDC Testing Update, Identifying and Treating Women at Risk and its Complications, HIV/HCV Co-Infection Update, HIV Reproductive Health, and Mental Health Co-Morbidities among the HIV infected.

- Nurse Coordinator attended a workshop put on by the Consumers for Affordable Health Care. This workshop went over how to screen for MaineCare eligibility by using household determinations, income, assets, deductions, and special populations. Other eligibility categories discussed included: seniors, non-categoricals and people with disabilities. This workshop included examples where participants were able to go through the steps to screen for eligibility.

- Attended a meeting with Kennebec Behavioral Health. Discussed ways of collaboration and resources available for our members/clients.

- **Minority Health: HIV/AIDS Care In the New Millennium**
  Nurse Coordinator attended an interactive symposium with discussions by Nathaniel James, MD, USCIS Civil Surgeon, Medical Director of MMC International Clinic; Eric Kabanda, Medical Interpreter; Paul Revier, LCSW from Community Counseling; finishing with a panel of Robert P. Smith MD, Sandra Putnam, FNP, Aju Daniel, MD and Doug MacQueen, MD. The discussions were informative and the group relayed the importance of having more gatherings to further develop interaction with agencies and discuss issues, barriers to care, and continuity of care.

- **2nd Wellness for Native Americans Conference: Walking a Path toward Healing**
  Nurse Coordinator attended conference. The first speaker was Dr. Benjamin Huerth, Medical Director at Penobscot Nation Health Department. He spoke of his program of pain control using drugs and therapy. The second speaker was Dr. Rebecca Sockeson, a Professor at a University in Canada. She spoke of Intergenerational Trauma and Oppression focusing on ways of knowing and ways of being, intrinsic to knowledge production and transfer of healing, wellness and prevention. The third speaker was an Infectious Disease specialist from Massachusetts, who spoke of issues with the older population of aging with HIV, both first diagnosed at an older age and the aging process with the diagnosis. Nurse Coordinator also attended breakout sessions on funding and then a summary of the day.

- Spring poster and brochure mailing sent to approximately nine hundred twenty (920) sites. Sites included soup kitchens, homeless shelters, doctor offices, case management agencies, hospitals, and local DHHS offices.

- Developed and sent new authorizations/releases to all of our members (Waiver and Medicaid). This form was revised by the Attorney General's Office. The form allows the Office of MaineCare Services to share and obtain information from/with a member's providers, case managers, and the AIDS Drug Assistance Program.

Provider Network

Demonstration enrollees continue to use the same network of providers as Medicaid members, whether for primary care or specialty care providers. There are two hundred forty one (241) distinct providers (Primary Care Providers and Infectious Disease Specialists) currently seeing our active members. These providers are located throughout all sixteen (16) counties.

Some members find the travelling distance from Northern Maine to a more populated area (Bangor) for an Infectious Disease Specialist challenging. MaineCare covers the cost of transportation; however, time and health conditions often make it difficult for some members.

Children continue to have access to two pediatric providers in the state of Maine. One pediatric provider prefers that her patients go to Massachusetts General Hospital, for evaluation and follow up, at least once or twice per year.

Quality Assurance

One of the goals of the Waiver is to delay disease progression by following up with members and providers through various activities.

Such activities in SFY12 included:

- Contact data and call tracking – incoming and outgoing contacts (phone calls, emails, letters, and faxes) to members, case managers, and providers are tracked and maintained in the database allowing us to determine the types of services being utilized. The total for both incoming and outgoing contacts of all services increased fourteen and a half percent (14.5%) in the tenth year over the

ninth. The three highest service contacts in SFY 2012 in order are case management, eligibility, and adherence;

- Medication adherence and compliance reports;

- Contact with providers, case managers, and the OMS Provider Relations unit to assist with benefit and policy questions and billing issues;

- Survey of all members living with HIV/AIDS in regard to quality of life and satisfaction conducted in the winter of 2011;

- Survey of all providers working with HIV/AIDS MaineCare members with regards to provider needs and satisfaction was conducted in the spring of 2011;

- Collected clinical data (viral loads and CD4s) from providers to show health status and track disease progression;

- Member Complaint Report (see page 22 of this document for more information).

Opportunistic Infections (OI)

There were five hundred two (502) distinct Demonstration enrollees during SFY2012. Distinct MaineCare members totaled three hundred fifty nine (359). Distinct member counts are higher than end of the year counts as they capture everyone who was a member during the year.

The most common OI was Other Lymphomas with eight (8) Demonstration enrollees and seven (7) Medicaid members or 1.60% and 1.95%, respectively. The next two most prevalent conditions were Candidiasis with seven (7) Demonstration enrollees and six (6) Medicaid members or 1.40% and 1.67% respectively, and Viral and Bacterial

Pneumonias with four (4) Demonstration enrollees and eight (8) Medicaid members, or 0.80% and 2.23% respectively. The top three OIs for SFY2012 were Other Lymphomas, Viral and Bacterial Pneumonias and Candidiasis. Other OIs occurred at low rates. Only thirty one (31) distinct members, or 6.19%, of the demonstration enrollees had an OI as compared to the thirty six (36) distinct members, or 10.03%, of Medicaid members.

The ten AIDS defining conditions are Actinomycosis, Coccidiosis, Cryptococosis, Cryptosporidiosis, Opportunistic Mycosis, Oral Hairy Leukoplakia, Other Named Varient of Lymphosarcoma, Other Specified Infections and parasitic Diseases, Salmonella Diseases, and Strongyloidiasis. Of these ten AIDS defining conditions, there was one Medicaid member that had Strongyloidiasis. None of the Demonstration enrollees had these AIDS defining conditions.

Women's Healthcare

One hundred eighty four (184) distinct women over 18 years of age were enrolled as demonstration enrollees or Medicaid members in MaineCare. Of the 184, fifty eight (58) were demonstration enrollees (32%) and one hundred twenty six (126) were Medicaid members (68%).

Sixty six percent (66%) (38 of 58) of female demonstration enrollees were at least 40 years old. Sixty four percent (64%) (81 of 126) of female Medicaid members were at least 40 years old. Twenty eight percent (28%) of demonstration enrollees and 33% of Medicaid members were screened for breast cancer using mammography. Twenty two percent (22%) of demonstration enrollees and twenty two percent (22%) of Medicaid members were screened for cervical cancer using a pap smear. Many members have a third party insurance. For these members, their primary coverage often pays for these services. MaineCare Services has no way to track, monitor, or count those claims.

Tuberculosis Testing

This measure is difficult to determine using claims data because providers rarely bill for this service separately. There were no cases of Tuberculosis in SFY2012.

Hospitalization Rates

- Emergency Room (ER) Services – one hundred forty six (146), or twenty nine percent (29%), of demonstration enrollees received ER services during SFY2012, compared to one hundred sixty three (163), or forty five percent (45%), of Medicaid members. Demonstration enrollees had a nine percent (9%) decrease in usage over SFY2011, while Medicaid members had a two percent (2%) increase. The top ER diagnoses were Chest Pain NEC, Bronchitis NOS, Headache, and Human Immuno Virus Dis. The Nurse Coordinator and other staff continue to work with members, their providers, and their case managers to reduce ER utilization.

- Physician Visits – four hundred four (404), or eighty percent (80%), of demonstration enrollees were seen by physicians during SFY2012, compared to three hundred twelve (312), or eighty seven percent (87%), of Medicaid members. Demonstration enrollees had a two percent (2%) decrease over SFY2011, while Medicaid members had a five percent (5%) decrease.

- General Inpatient Services – forty eight (48), or ten percent (10%), of demonstration enrollees were admitted to the hospital during SFY2012, compared to forty eight (48), or thirteen percent (13%), of Medicaid members. Demonstration enrollees usage decreased five percent (5%) over SFY2011, while the Medicaid members had a two percent (2%) decrease. The top inpatient diagnoses were Human Immuno Virus Disease, Septicemia NOS, and Alcohol Withdrawal.

- Inpatient Mental Health Services – No Demonstration enrollees and no Medicaid members used Inpatient Mental Health Services during SFY2012.

Adherence to Therapy

Medication compliance calls totaled two hundred eleven (211) for SFY2012. Compliance calls are structured to provide interventions for members in various groups based on their CD4 count. Medication adherence calls totaled five hundred sixty-six (566) for SFY 2012. Barriers continue to be identified and removed, when possible.

Death Rates

Eleven (11) enrollees or members died during SFY2012. Of the deceased members, four (4) were demonstration enrollees, which decreased by four (4) from SFY2011. Of the deceased members, seven (7) were Medicaid members, which represented a decrease of three (3) over SFY2011. A total of one hundred forty one (141) members have died since the beginning of the Demonstration Project. One hundred four (104) of the deaths were Medicaid members and thirty seven (37) were demonstration enrollees.

Disenrollment

Seventeen (17) demonstration enrollees moved to receive full MaineCare services, nine (9) members re-enrolled as 5Bs (demonstration enrollees), forty eight (48) demonstration enrollees are no longer enrolled in the MaineCare, and four (4) demonstration enrollees died during SFY2012.

Policy and Administrative Overview

Complaints/Grievances:

There are three points of contact for questions, concerns or complaints:

1. The MaineCare Member Services helpdesk has a toll-free number to answer questions or resolve complaints. The contacts are logged in a tracking database. If the contact is related to the waiver program and the issue is not resolved, it is referred to the Nurse Coordination for more detailed assistance.

2. Ryan White Case Management agencies also receive concerns or complaints from demonstration enrollees or MaineCare members via personal contact, calls, or emails and notify the nurse or program coordinator when additional assistance is needed.

3. Direct calls, emails, or written correspondence is also made directly to the Nurse Coordinator.

All of the complaints, concerns, or questions received are then entered into an electronic tracking system for resolution and tracking.

In SFY2012 there were three (3) complaints, all of which came from members. All of these complaints were resolved.

Accomplishments

MaineCare Services and the HIV Program have undergone a number of changes in the last three years. Some of these changes included, switching to a new claims and reporting system, staff turnover, and changes to the algorithm and program reports.

The Demonstration has had many accomplishments over the past ten years. Some of the accomplishments are listed below.

- Maine has continued to make improvements with care management and cost saving initiatives. Demonstration enrollees had a nine percent (9%) decrease in Emergency Room use over last year. We have worked hard to ensure all members have a primary care doctor and access to needed services to avoid unnecessary Emergency Room use.

- MaineCare monitors and follows up on preventative measures such as Mammograms and pap smears. For the Demonstration population, there was a twenty three percent (23%) increase in mammography screenings for women over forty (40) from State Fiscal Year (SFY) 11 to SFY12.

- Member satisfaction rates with the program have continued to increase. In 2009, our annual member satisfaction survey showed a satisfaction rate of around seventy eight percent (78%). In 2011, the satisfaction rate had increased to around eighty four percent (84%).

- Budget neutrality has been maintained. Through the end of 2012, the Waiver was cumulatively $46,469,534.92 under the budget cap.

- Increased substantial statewide awareness of the existence of the benefit.

- Significantly increased collaboration and interaction among the Office of MaineCare Services (OMS), Maine Center for Disease Control and Prevention (including Ryan White services), AIDS Service Organizations (case management), AIDS Drug Assistance Program (ADAP).

- Better coordination of care; evaluation and analysis of member and provider surveys.

- Continued compilation of a unique database that, over time, will help us better understand utilization and disease progress in members living with HIV/AIDS.

- Improved medication adherence and compliance with members. The Nurse Coordinator is targeting calls to members with high viral loads or low CD4 counts.

- Continued to work with providers to collect members lab data (CD4 and viral load).

- Collaborated with pharmacy manager and the drug companies to make the Drug Utilization Review (DUR) team aware of the newest HIV medications for MaineCare's formulary.

- Collaborated with Maine Centers for Disease Control (CDC) to provide care management services.

- Ensured all members are linked with an Infectious Disease and Primary Care Physician within their area.

- Completed designing and implementing new care management and claims system.

- Revised Medicaid algorithm logic to eliminate the prescription criteria as it was no longer sufficiently identifying members.

- Developed and implemented new processes for care management calls. A call queue through an Access database was created. This queue organizes care management reports and prioritizes calls by using a schedule. The Nurse Coordinator also began the process of calling an 'unreachable' member twice and then sending a No Contact Letter. Unreachable members often call back after receiving the letter. These new data systems and processes have shortened the duration of time between calls to members and improved member satisfaction.

- There have been several quality assurance report improvements.

    - The monthly adherence and compliance reports were changed to include a process that checks each member's latest CD4 results to more accurately categorize members by disease stage. A new compliance report was created for members who have no CD4 result on record, and the logic for the adherence report was changed to include members with no CD4 result. The logic for both the adherence and compliance reports were altered to better define enrolled members. A new field showing the member's last contact date was also added in order to better inform the Nurse Coordinator and to improve outreach to outdated contacts.

    - A new report and report process were created for both our ER report and Mammogram/Pap Smear report. This was done in order to coordinate the old reports with the new claims system. The ER report is now implemented in our Access database, and requires a data import from the claims system, after which the logic is run using a macro which automates this process. This new process allows for more timely monthly report updates. There were also

several fields added to the report to make it more informative for the Nurse Coordinator, as well as 6-month tracking that allows for a more complete member profile. The logic for the Mammorgram/Pap Smear report was updated to better distinguish members who have not had a mammogram and pap smear, as well as to take into account members who have a third party insurance or primary coverage that may be covering these visits.

- Worked with case managers and ADAP to provide intervention to members in the month of their MaineCare review to prevent members from "cycling off" and having a lapse in their health care coverage.

Compliance and Changes to Special Terms and Conditions

Maine is requesting the following changes to the current Special Terms and Conditions (STCs) of the demonstration:

Maine will be going through rulemaking to update Chapter X – Section 1: Benefit for People Living with HIV/AIDS. The changes will impact page eight (8) of the STCs. Some of the MaineCare Benefits Manual (MCBM) policy references are incorrect. Once the rulemaking process has been completed, we will notify CMS of the changes that need to be made to this list.

The Policy references that will be updated are as follows:

- Case management services are in section 13.02;
- STD testing/VD screening is now covered under other sections (such as Section 30 and 90);
- Psychology Services are now covered under Section 65; and,
- Substance Abuse treatment is now covered under Section 65.

Maine is requesting the premiums for the renewal period (page 14 of the STCs) be updated to the following:

Demonstration Year (DY)	Actual Premium, Income Level <150% FPL	Actual Premium, Income Level 150 – 200% FPL	Actual Premium, Income Level 200 – 250% FPL
DY12 1/2014 – 12/2014	$0	$32.59	$65.17
DY13 1/1/2015 – 12/2015	$0	$34.22	$68.43
DY14 1/1/2016 – 12/2016	$0	$35.93	$71.85

The due date of the Final Evaluation Report on page 23 of the STCs is incorrect. The date should be 09/01/2014.

The table displaying the budget neutrality expenditure caps on page 21 of the STCs needs to be updated with the extension request demonstration years. The new table should include:

Year	Without Waiver	Allowed Margin
DY11 7/2012 – 12/2013*	$22,237,601	0
DY12 1/2014 – 12/2014	$13,340,759	1
DY13 1/2015 – 12/2015	$17,232,086	.5
DY14 1/2016 – 12/2016	$20,570,140	0

See the Renewal Model 'Actual+ProjectedCosts' spreadsheet for more information.
*Without waiver costs for DY11 7/1/2012 – 6/30/13 have not been revised from the previous STCs. The without waiver costs for DY11 7/1/2013 – 12/31/13 have been revised to reflect the projected costs seen in the WOW spreadsheet included in the

renewal model. These two amounts have been added together to get the total without waiver cost for DY11.

On page 20 of the STCs the last three sentences should now read: "The aggregate financial cap is determined by applying the President's 2010 Budget trend rate to the Demonstration year 11 annual budget limits to obtain annual budget limits for the Demonstration year 12, 13, and 14 (the 3-year renewal period). The State's modeling for the renewal period included annual budget limits based on disease-stage-specific PMPMs. The budget neutrality cap will be for the total computable cost of $192,289,760 for the life of the Demonstration."

MaineCare Services and the HIV Program have undergone a number of changes in the last three (3) years. Some of these changes include, switching to a new claims and reporting system, staff turnover, and changes to algorithm and program reports.

One of the barriers we encountered relates to the waiver's cost sharing measures. The Demonstration has cost sharing measures for enrollees. These measures include co-payments and premiums. Enrollees pay a co-payment for Physician Services and pharmaceuticals that are higher than MaineCare member co-payments. Enrollees are also responsible for payment of a monthly premium that is based on income level. Premiums are scheduled to be increased by 5% annually. MaineCare was a year late on the Demonstration Year (DY) 10 increase. Since this increase occurred late (June 1, 2012), it was decided to also delay the DY11 increase (originally scheduled to happen in July 2012) to avoid back to back increases. To avoid future delays like this, it was decided that MaineCare should only go to rulemaking once for the premium increases rather than going every year for each increase. Going to rulemaking once for these increases is not only timelier, but also more cost effective for the state. For the proposed increases in the renewal period, MaineCare will go to rulemaking once and list all of the increases in the Policy. This will avoid being late due to the time constraints involved in the rulemaking process.

During the switch to our new claims and care management system, the Maine Integrated Health Management Solutions (MIHMS), Maine encountered some problems and inaccuracies with program reports. MaineCare Services had to send draft reports to CMS until these inaccuracies were resolved. Maine has since resubmitted final versions for all draft reports that were submitted.

Documentation of the State's Compliance with the Public Notice Process

The Office of MaineCare Services has used many mechanisms to inform interested parties about the Waiver extension application to solicit public input. The public notice and public input procedures were developed to ensure compliance with the requirement specified in 42 C.F.R. § 431.408.

Public Notice and Input Procedures

The State's 30-day public notice comment period began on February 28, 2013. A comprehensive draft of the application to be submitted to CMS was made available for public review and comment on the state's website. The state also developed an abbreviated public notice which included a summary of the demonstration, the locations, dates, and times of the two (2) public hearings, and a link to the full public notice on the State's website (see appendix A). This abbreviated public notice was published in the following newspapers on March 2, 2013: *Kennebec Journal*, *Portland Press Herald*, *Waterville Morning Sentinel*, *Lewiston Sun Journal* and the *Bangor Daily News*.

Maine has worked hard to develop an effective tribal consultation process. Maine has five (5) federally recognized Indian tribes whom we consult with and receive comments. Table 1 below shows the tribes' involvement in the renewal process. Further information can be provided, if necessary.

Table 1 summarizes the State's public notice and public input process for this waiver extension request.

Table 1: Summary of Public Notice and Input Processes

Public Notice and Input	Date	Requirement
HIVAC discussed waiver extension	April 10, 2012	42 C.F.R. § 431.408(a)(1)(iv)
Email sent to Tribal Health Directors and Chiefs	July 27, 2012	42 C.F.R. § 431.408(b)
Package sent to Tribal Health Directors	July 30, 2012	42 C.F.R. § 431.408(b)(2) and (3)
Tribal Call	August 7, 2012	42 C.F.R. § 431.408(b)
Public notice and comment period begins	March 1, 2013	42 C.F.R. § 431.408(1) (Posted OMS Website)
Interested Parties Letter (see appendix B)	February 28, 2013	42 C.F.R. § 431.408(a)(3)(iv)
MAC discussed waiver extension	October 2, 2012	42 C.F.R. § 431.408(a)(3)(i)
HIVAC discussed waiver extension	October 9, 2012	42 C.F.R. § 431.408(a)(3)(ii)
Public Hearing	April 3, 2013	42 C.F.R. § 431.408(a)(3)
Public notice and comment period ends	May 3, 2013	42 C.F.R. § 431.408(a)

Any additional materials needed that document the State's compliance with public notice and input requirements can be provided upon request.

Issues Raised by the Public during the Public Notice and Input Period

The Department provided notice and comment period regarding the waiver renewal. The Department received input and comments at two public meetings as follows: 1.) MAC meeting on October 2, 2012 and 2.) HIVAC meeting on October 9, 2012. The Department also provided a public notice and comment period regarding the waiver renewal. Through an Interested Parties mailing, electronic posting on the Department's internet website, as well as a statewide publication in five (5) in-state newspapers, the Department gave notice that a Public Hearing was scheduled for April 3, 2013 at the Office of MaineCare Services. The Department notified all interested parties that written comments were welcomed and should be received by midnight, Friday, May 3, 2013. Thus, MaineCare's public notice and comment period began February 28, 2013 with the mailing of the Interested Parties Letter on February 28, 2013 and ended May 3, 2013 when the deadline for receipt of comments expired. During this time, a comprehensive draft extension request was available for public review and comment. Comments could be received through email, mail, telephone, and at the public hearings. One comment was received during the public notice and input period (see appendix C).

Post-Award Public Input Process

MaineCare Services will comply with all post award public input requirements. Within six months of the renewal of Maine's HIV/AIDS Demonstration (anticipated to begin January 1, 2014), Maine will hold a public forum to solicit comments on the progress of the demonstration. MaineCare services will continue to hold similar forums annually throughout the extension period. MaineCare will publish the date, time, and location of each public forum. MaineCare will provide comments from these forums in the corresponding quarterly reports as well as the annual reports.

Summary

Over the course of the ten years of this demonstration, the Office of MaineCare Services has continued to improve access to medical services for Maine residents. The 1115 Demonstration Project has provided medical services to five hundred and two (502) demonstration enrollees. In addition, three hundred fifty nine (359) Medicaid members had the benefit of enhanced care coordination. In just the last year, personal contacts were made through meetings with agencies, such as the AIDS Drug Assistance Program (ADAP)/Ryan White Title B, Physician Advisory Committee (PAC), Ryan White Case Management Agencies, Office of Family Independence (OFI), Maine Center for Disease Control & Prevention (MeCDC), educational workshops with members, educational trainings with counselors and providers and visits with the case managers. Posters and brochures continue to be distributed throughout the state to OFI regional offices, pharmacies, physician offices, hospitals, and municipalities. Mailings include homeless shelters, family planning agencies, high schools and colleges to help broaden the awareness within communities.

The Waiver costs continue to be well below the budget neutrality permitted under the Waiver. It is clear to us that the Waiver has brought substantial health benefits to both members and enrollees. Keeping individuals more healthy is the key to managing HIV.

Appendix A

NOTICE OF AGENCY 1115 HIV/AIDS WAIVER RENEWAL

AGENCY: Department of Health and Human Services, MaineCare Services

CONCISE SUMMARY: Maine is requesting to renew the Maine HIV/AIDS Section 1115 Demonstration Waiver under the Social Security Act effective January 1, 2014. The objective of this waiver is to provide more effective and earlier treatment, improve access to continuous health care, provide a comprehensive package of services to people living with HIV/AIDS, to assist in enhancing compliance with treatment and medication regiments, and to meet cost-effectiveness as required by federal regulations. The key feature of this waiver which allows for the objectives to be successfully accomplished is the care management services. Maine is not anticipating any impact on enrollment or spending unless a Medicaid expansion occurs. If so, some enrollees would move from the waiver to full MaineCare benefits.

Maine does not anticipate asking for any substantial modifications to the existing Section 1115 Demonstration waiver. Maine has continued to make improvements with care management and cost saving initiatives. Member satisfaction rates with the program have continued to increase. In 2009 our annual member satisfaction survey showed the satisfaction rate had increased to approximately 78% and in 2011 the satisfaction rate had increased to approximately 84%. The waiting list has not been utilized during State Fiscal Year 12 for this project, as the cost of patient care is not projected to exceed the project allotment. However, the State may institute a cap in the future should budget estimates indicate costs will exceed the project allotment.

Members are eligible for transportation services under a 1915(b) waiver. Transportation Services are provided to enable members to gain access to waiver services. The transportation services are available only through the MaineCare Benefits Manual, Chapter II, Section 113 (Transportation Services). Chapter X, Section I waiver providers are not reimbursed for transportation services provided to waiver members. Transportation services under the waiver are provided in accordance with the member's Waiver Service Plan. Whenever possible, family, neighbors, friends, or community agencies who can provide transportation services without charge, must be utilized.

See http://www.maine.gov/dhhs/oms/rules/demonstration-waivers.shtml

The Department has provided a public notice and comment period regarding the waiver renewal. The Department received input and comments at two public hearings held as follows:

MAC Meeting

Date: October 2, 2012 at 11 am
Location: 41 Anthony Street
Augusta, ME 04330

HIVAC Meeting

Date: October 9, 2012 at 9:30 am
Location: 11 Parkwood Drive
Augusta, ME 04330

The Department is also providing a 30-day public notice and comment period regarding the waiver renewal as follows:

Public Hearing
Date: April 3, 2013 at 10 am to 12 p.m.
Conference Room 1
Department of Health and Human Services
Office of MaineCare Services
242 State Street
Augusta, ME 04330

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before Monday, March 29, 2013.

Written comments may be sent at the postal address MaineCare Services, Policy Division, 242 State Street, 11 State House Station, Augusta, Maine 04333-0011 and reviewed by the public at the following Internet address:

http://www.maine.gov/dhhs/oms/rules/demonstration-waivers.shtml

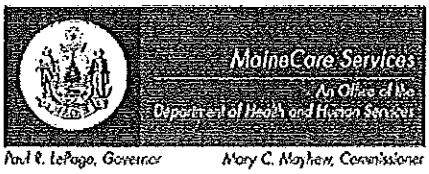
Public notice will also be given through in-state newspaper publication.

DEADLINE FOR COMMENTS: Comments must be received by midnight, Friday, May 3, 2013.

AGENCY CONTACT PERSON: Michael J. Dostie, J.D.
AGENCY NAME: MaineCare Services
ADDRESS: 242 State Street
11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: 207-287-6424 FAX: (207) 287-9369
TTY: 711 (Deaf or Hard of Hearing)

Appendix B



Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
MaineCare Services
Policy Division
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9368; Fax: (207) 287-9369
TTY Users: Dial 711 (Maine Relay)

DATE: March 1, 2013

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Renewal of the Maine HIV/AIDS Section 115 Demonstration Waiver under the Social Security Act and MaineCare Benefits Manual, Chapters X, Section 1, Benefit for People Living with HIV/AIDS

This letter gives notice of the Department's request to the Centers for Medicare and Medicaid Services (CMS) to renew the Maine HIV/AIDS Section 1115 Demonstration Waiver under the Social Security Act effective January 1, 2014. The objective of this waiver is to provide more effective and earlier treatment, improve access to continuous health care, provide a comprehensive package of services to people living with HIV/AIDS and to assist in enhancing compliance with treatment and medication regiments. The key feature of this waiver that allows for the objectives to be successfully accomplished is the care management services. Maine is not anticipating any impact on enrollment or spending unless a Medicaid expansion occurs. If so, Maine expects to see a 60% reduction in the current waiver membership.

Nor does Maine anticipate asking for any substantial modifications to the existing Section 1115 Demonstration waiver. Maine has continued to make improvements with care management and cost saving initiatives. Member satisfaction rates with the program have continued to increase. In 2009 our annual member satisfaction survey showed satisfaction rate had increased to around 78% and 2011 the satisfaction rate had increased to around 84%. The waiting list has not been utilized during State Fiscal Year 12 for this project, as the cost of patient care is not projected to exceed the project allotment. However, the State may institute a cap in the future should budget estimates indicate costs will exceed the project allotment.

Members are eligible for transportation services under a 1915(b) waiver. Transportation Services are provided to enable members to gain access to waiver services. The transportation services are available only through the MaineCare Benefits Manual, Chapter II, Section 113 (Transportation Services). Chapter X, Section I waiver providers are not reimbursed for transportation services provided to waiver members. Transportation services under the waiver are provided in accordance with the member's Waiver Service Plan. Whenever possible, family, neighbors, friends, or community agencies who can provide transportation service without charge, must be utilized.

Rules and related rulemaking documents may be reviewed at, http://www.maine.gov/dhhs/oms/rules/demonstration-waivers.shtml or printed from, the MaineCare Services website at or for a fee, interested parties may request a

paper copy of rules by calling (207) 287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A concise summary of the Maine HIV/AIDS Section 1115 Demonstration Waiver is provided in the Notice of Agency 1115 HIV/AIDS Waiver Renewal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency 1115 HIV/AIDS Waiver Renewal,

Appendix C

FRANNIE PEABODY CENTER
comprehensive HIV & AIDS services

www.peabodycenter.org

May 2, 2013

In re: 1115 HIV/AIDS Waiver Renewal

Frannie Peabody Center, the largest HIV/AIDS service organization in Maine, would like to offer our unreserved support for the renewal of Maine's Section 1115 Demonstration Waiver for people with a diagnosis of HIV/AIDS.

The Maine HIV/AIDS Section 1115 Demonstration Waiver is an effective, cost neutral project that allows hundreds of men and women to receive expert medical care to treat their HIV and remain productive in their respective communities. The providers in our agency see the benefit of this waiver each and every day as their clients access affordable health care, targeted case management and necessary transportation services (via 1915 (b) waiver).

Frannie Peabody Center specializes in providing targeted case management, a successful and evidence-based approach to caring for people living with complex medical needs. Case management shifts the coordination of treatment to a cost effective model of service, allowing the HIV medical providers to concentrate their efforts on patient care and treatment. It reduces ER visits and provides a framework for patients who often struggle with debilitating medication side effects and complicated treatment requirements. Case managers coordinate care and focus on treatment adherence, including socioeconomic factors that might interfere with treatment success. These can include access to healthy food, medication reminders, coordination of specialty care, translation services, housing stability and coordinating transportation to medical appointments.

The HIV/AIDS Demonstration Waiver is held in high regard throughout the HIV provider community. It has clearly provided many working people and people with low incomes access to HIV care, people who otherwise would not be able to afford medical care at all. Left untreated, HIV batters the immune system until it is devastated. Research shows that early diagnosis and treatment for HIV lengthens life expectancy and reduces transmission of the virus. The HIV/AIDS Waiver provides integral insurance coverage in a cost effective manner and Frannie Peabody Center is grateful to be a part of such a successful demonstration waiver. Our clients, our community and our state will benefit and we fully support renewing the 1115 HIV/AIDS Demonstration Waiver.

Patti Capouch, Executive Director
30 Danforth St. Suite 311
Portland, ME 04101
(207) 774-6877 x 8011
pcapouch@peabodycenter.org

MAINE HIV/AIDS DEMONSTRATION PROJECT (WAIVER)
BUDGET NEUTRALITY CALCULATION

This report documents the methodology the State used to calculate budget neutrality for its HIV/AIDS Waiver.

I. Background

Maine was granted a 5-year Section 1115 HIV/AIDS Demonstration Waiver in 2002. In 2007 and again in 2010, the Waiver was renewed for an additional three years. The waiver is scheduled to end on December 31, 2013. The State is requesting to extend the Waiver for another three years until December 31, 2016.

The Section 1115 HIV/AIDS Demonstration Waiver (Waiver) consists of two groups: 1) "Members" who are MaineCare members identified as HIV-positive with their HIV costs being at least 25% of the total costs of care; and 2) "Enrollees" who do not meet the eligibility requirements of MaineCare, but who are HIV positive and at or below 250% of the federal poverty level.[1]

As of June 30, 2012, we had 417 enrollees and 195 members for a total population of 612 participants. We estimate that the Waiver covers approximately 50% of the 1616 known HIV-infected Maine residents. The growth rate of HIV infection in Maine has continued to slow down over the past 3 years to an average of 7.2% per year. During the entire Waiver program, membership grew from 421 members to 612 members, an average growth rate of 4.2% annually. We have used an expected Waiver growth factor of 2.9% per year for the extension period and, on that basis, project the Waiver program will have 639 participants at the start of the period and will grow to 696 participants by the end of the proposed extension period.

Our original Waiver application indicated budget neutrality would be maintained if the total Waiver costs were no higher than $58.5 million for the first 5 years of the program. For the first five years of the Waiver, the costs were approximately $35.8 million. For the first ten years of the program, total costs have been $82.9 million. We project that the total cost of the Waiver over the 14 demonstration years will be $158.3 million through 12/31/2016.

We project that it will cost less to extend the Waiver than it would to end the Waiver. We forecast the 3-year cost to extend the Waiver will be approximately $56.7 million. In the absence of the Waiver, we estimate that the 3-year total cost will be $59.5 million. Beyond the fiscal impact of not having the waiver on waiver participants, loss of the

[1] Members receive all of the medically necessary covered MaineCare services, while enrollees receive a targeted essential set of MaineCare services that includes inpatient and outpatient hospital care, physician care, laboratory monitoring, psychiatric and substance abuse services, social service support, and prescription medications. Enrollees contribute for the cost of their care with co-payments for medicines and for physician visits, and monthly premiums for some enrollees.

waiver would hamper the ability of other programs to meet the needs of the HIV population statewide.

It is difficult to accurately reflect the availability and resources of other Federal programs without the Waiver since the elimination, or even capping enrollment of the Waiver would affect the availability and resources of the other programs. Without the waiver, these other programs would not be able to continue assisting members on the same basis as they do currently.

The potential impact of the loss of the waiver has been discussed in collaboration meetings with the Center for Disease Control and Prevention and with the AIDS Drug Assistance Program. Without the Waiver, these programs would incur more costs which would cause their funding to deplete more quickly because without the Waiver's healthcare coverage, the disease would progress more rapidly and the members would ultimately cost the other programs more money because they would be further along in the progression of their illness, as we have modeled in the without waiver scenario. It has been concluded that if cuts were made to the Waiver program, then the other programs would have to make cuts and program changes. These changes could include such things as; lowering the federal poverty level (for determining eligibility), and making cuts to the pharmacy formularies. These changes would adversely affect the health and care of our HIV population.

II. Budget Neutrality Model Overview

When the State applied for the HIV Waiver in 2001 and again for a Waiver extension in 2007 and 2010, we used a model called a Markov Process mathematical model, to demonstrate budget neutrality. This model, along with the resulting budget figures, was reviewed by the Centers for Medicaid and Medicare Services (CMS) and the Office of Management and Budget, and approved by CMS. We used the same cost-neutrality model for this Waiver extension application.

Moore and colleagues at The Johns Hopkins School of Medicine developed a Markov Process model for HIV infection that estimates rates of disease progression with various levels of healthcare, and moves an individual from state to state according to a set of disease-state-specific probabilities.

The State used the model and derivations of disease progression built into the model to estimate disease progression with and without antiretroviral treatment. We used information from medical literature and the experience of the Maine Medical Center Viral Treatment Center to estimate rates of disease progression with modern antiretroviral treatment. We then interpolated between the historic rate of disease progression and rates of disease progression with an ideal antiretroviral therapy regiment to estimate the effects of interruptions in treatment through antiretroviral medication and lack of nurse-based care management.

The model tests effects of changes in the amount and quality of care on disease outcomes via its Markov process disease state transition probabilities. Improvements in care have improved possible outcomes since 1998 when the model was first developed. However, those outcomes are optimal outcomes. The with-waiver disease state transition probabilities have not been changed from the original 1998 values, as they continue to reflect actual experience with our HIV Waiver program. Without-waiver probabilities are set to an intermediate point between outcomes in the pre-HAART era and the modern era as reflected in our with-waiver probabilities.

We tested the effect of changes to the without waiver probabilities in our sensitivity analysis and find that cost neutrality is relatively insensitive to changes in the without-waiver transition probabilities. The without-waiver estimates include availability of Ryan White and other possible funding sources of treatment by assuming that patients would get treatment which is, on the average, ½ as effective as the treatment available under the waiver. This assumption takes into account limitations of the Ryan White and other funding sources.

The Markov Process model uses four disease states based on the patient's CD4 count:

Disease State	CD4 count
Asymptomatic HIV Infection	>350
Symptomatic HIV Infection	200-350
AIDS	< 200
Death	

When we applied for the original Waiver we did not have access to a member's CD4 counts, so we developed an algorithmic method to estimate the disease state of each HIV-infected MaineCare member. We assign each member's disease state based upon the latest CD4 count available. When CD4 counts are not available, we continue to assign the member's disease state algorithmically. We are therefore able to calculate disease-state-specific per-month cost of care for enrollees and MaineCare members.

We then developed two scenarios: a "With Waiver" (WW) and a "Without Waiver" (WOW). We interpolated between the ideal treatment Markov Process model and the without-treatment Markov Process model to estimate the effects of losing the Waiver on the loss of medical care, interruption or loss of antiretroviral regimens, and loss of care management. From this information, we developed an overall cost equation:

Budget Neutrality Equation:

Total With-Waiver Demonstration Cost + Total With-Waiver MaineCare Cost

≤ Total Without-Waiver MaineCare Cost

Where

Total With-Waiver Demonstration Cost = ∑(Disease-State-Specific Demonstration Membership * Disease-State-Specific Cost Per Demonstration Member)

Total With-Waiver MaineCare Cost = ∑(Disease-State-Specific MaineCare Membership * Disease-State-Specific Cost Per MaineCare Member)

Total Without-Waiver MaineCare Cost = ∑(Disease-State-Specific MaineCare Membership * Disease-State-Specific Cost Per MaineCare Member)

With-Waiver Costs ≤ Without-Waiver Costs

III. Explanation of the Budget Neutrality Model Spreadsheets

The attached Excel workbook contains actual membership and expenses over the first 10 years of the Waiver, the cost neutrality model, and the 3-year extension budget. The 2013 enrollment and cost data are forecasted based on SFY2003-SFY2012 data. The workbook contains eight spreadsheets:

- HIV Infection & Membership – Maine CDC estimates of Maine residents living with HIV, and Waiver membership
- Cost Data – Total and per-member-per-month costs stratified by Waiver program and disease status.
- Premiums – Waiver program Enrollee premiums stratified by member poverty status and average per-member monthly premium yield. These premiums offset the with-waiver program costs;
- Model Params (Parameters) & Sens (Sensitivity) Analysis – Membership estimates and other model parameters used in the model. Membership growth rate is our best estimate based on Waiver growth rate over the last 3 years and overall growth rate of HIV infection in Maine.
- Model Disease Transition Probabilities and Spectrum – the without antiretroviral treatment probabilities are derived from the Hopkins model described above. The with-waiver probabilities are derived from our Waiver program experience.
- Model PMPM's - per-member-per-month (pmpm) costs are derived from our actual program and disease-state-specific pmpm cost experience over the course of the Waiver. Because of the introduction of Medicare D, we have

ignored costs for FY03 through FY06. We trended costs forward 3 years to account for inflation from 2014 to 2016.
- Model – The actual model, which will be explained below in more detail.
- Budget.

Parameters and Sensitivity Analysis: This sheet contains estimates of membership and membership growth, estimates of the percentage of HIV-infected Maine residents who would transition to traditional MaineCare in the absence of the Waiver, and estimates of the effect of loss of MaineCare on disease progression rates. Note that the model was run for 6 years of extension, (periods 1-12), although the waiver extension application is for 6 periods or 3 years.

- Lines 6 and 30 show our membership growth assumption. The percentage of individuals covered under the waiver has decreased while the number of individuals living with HIV in Maine has increased. The enrollment growth rate is the same as the growth rate used for the last renewal.

  To get a more accurate picture of growth and costs, we use per member, per month (PMPM) growth instead of membership growth. The 2.9% growth rate is based on the PMPM increase from SFY2006-SFY2012. We believe the 2.9% growth estimate to be conservative, especially given current economic conditions both in-state and nationwide. We would like to increase the membership increase estimate in the model, but understand that the rate must be based on trends from the last waiver demonstration period. Changing the membership increase estimate would affect budget neutrality little, but would increase the overall budget and cost cap. Should MaineCare have larger than 2.9% pmpm increase, we plan to approach CMS to amend the waiver so that the budget cap can be adjusted accordingly.

- Lines 7-25 contain 4 sets of columns, showing average membership in the previous 3 years of the Waiver and estimated growth in Enrollee and Member populations for the Waiver. Lines 37-49 show the estimated growth in population without the waiver, (the Non-Waiver scenario), which is an estimate of the percentage of HIV-infected enrollees who would enroll in traditional MaineCare each year based on the member's disease status. For example, we estimate that an asymptomatic HIV-infected person presently enrolled in the Waiver would have a 35% probability of enrolling in MaineCare in the absence of the waiver.

- Lines 8 and 32 show the number of members in each program and disease state averaged over SFY 2010-2012. We used average figures because our disease-staging algorithm is imperfect and individual member disease assignment varies slightly from year to year.

- Lines 11 and 35 show the expected number of members by program and disease state at the beginning of the Waiver extension, which are extrapolated by

expected growth rate. This is calculated by increasing membership by 3 years using the annual pmpm membership inflation rate. Lines 13-25 and 37-49 show new members added during each semi-annual demonstration period for a total of 13 periods or 6 1/2 years, with an extra period included for the third half of DY11 (June-Dec. 2013) . These are estimated new members by stage for each period of the Waiver for each scenario. For each period, new members are estimated as members enrolled at the beginning of the demonstration plus the sum of new members from previous periods times one-half the annual membership growth rate.

- Lines 37-49: These lines show the Number of new enrollees and members for each period of a non-Waiver scenario. They are identical to the Waiver-scenario numbers in lines 13-25. As with the with-waiver new member calculations in lines 13-25, for each period, the optional population is estimated from the current optional population enrolled at the beginning of the demonstration plus the sum of new members from previous periods times one-half the annual membership growth rate. These numbers provide the "seed" for the calculations on how members would shift from not having MaineCare coverage to having the coverage. The calculations for how many members would have no coverage and then shift to MaineCare coverage once the model is plugged are on the model tab. These numbers show that growth in individuals who have HIV infection would be the same regardless of whether they have coverage or not. (They do not represent how many of the newly infected individuals would be in each category without the waiver.)

- Line 54: Annual per-member cost inflation: This number is set based on the inflation rate in the President's budget for these types of costs and was assigned by CMS at 7.92% for this waiver renewal period.

- Line 56 shows the monthly per-member Medicare D Clawback cost to MaineCare. This fee is the amount that MaineCare is charged by CMS for Medicare D coverage for dual-eligible members. Roughly one half of the mandatory Medicaid population served under the waiver and one third of the optional population served under the waiver are dual eligible.

- Line 71 contains our estimate of loss of care management on HIV disease progression.[2] This figure is used to interpolate between the ideal Markov Process transition probabilities and the classic no-anti-retroviral therapy transition probabilities used in the model. Line 93 contains our estimate of loss of the Waiver program on HIV disease progression, also used to interpolate between ideal therapy and no anti-retroviral therapy.[3] It is estimated that members would

[2] Mitchell, Jean M. and Anderson, Kathryn H: op cit, Health Affairs 19 No 4, July/August 2000

[3] Walensky RP; Paltiel AD et al: "The survival benefits of AIDS treatment in the United States" J Infect Dis. 2006 Jul 1;194(1):11-9. Epub 2006 Jun 1.

progress in their disease status 20% faster without care management. This is an estimate separate from the cost efficiency estimate of care management.

- Line 73 shows estimated savings achieved from the care management aspects of the Waiver program. This number is based on estimates of insurance company care management professionals. Line 73 contains our estimate of the cost savings from care management, ie, the estimated effect of the loss of the Waiver program care management on the quality "efficiency" of care. This estimate is in line with general estimates of cost savings quoted in medical literature.[4]

- Lines 77-137 contain sensitivity analyses which test the durability of our cost neutrality argument to changes in our estimates of the effect of care management, disease progression, and transition to traditional MaineCare if the Waiver program were removed. This shows the sensitivity analysis of this variable.

- Lines 81-91 show testing of the sensitivity of the loss of care management analysis. This shows at which point care management begins to save over not providing care management for the waiver period. The model shows that there is some savings starting at 10% improvement over 3 years of the waiver. This model does not include the savings that have already been realized from the provision of care management since the inception of the waiver, which would be much higher. This chart shows the degree care management has a positive impact on budget neutrality. It also shows that without care management, if other variables remained the same, budget neutrality would not be achieved.

- Line 93 shows the estimated effect of the loss of the Waiver on disease progression. This percentage is used to perform linear interpolation between pre-modern disease progression rates from the original Hopkins study and modern disease progression rates as found in the Waiver program. We estimate that some but not all effect on arresting of disease progression would be erased by loss of the Waiver program. Lines 98-112 show the sensitivity analysis of this variable. About 50% of optional members would have more rapid disease progression without waiver services.

- Lines 117 through 119 show how quickly optional members would move to Medicaid without the waiver based on disease progression estimates. Columns A-C contain estimates of the disease-state-specific annual rates of enrollment in

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[4] Mitchell, Jean M. and Anderson, Kathryn H: "Effects of Case management and new Drugs on Medicaid AIDS Spending", Health Affairs 19 No 4, July/August 2000

Handford CD, Tynal AM, et al: "Setting and organization of care for persons living with HIV/AIDS (Review)", The Cochrane Colla boration, 2006 No 3.

Personal communication, Joel Johnson, Care Management manager, Cigna Healthcare.

traditional MaineCare should the Waiver program not be extended. These estimates are derived from an understanding that most enrollees live at less than 150% of poverty. The cost of HIV treatment approximates or exceeds enrollees' income, and overall Waiver enrollment increases in past years have not exceeded the growth rate of HIV infection in Maine. For example, an asymptomatic HIV-infected person in the optional population presently enrolled in the Waiver would have a 35% 1-year probability of obtaining MaineCare in the absence of the waiver.

- Line 121 contains a "sensitivity factor" (a tool which allows us to test changes in our assumptions) which allows us to test the sensitivity of cost neutrality to those estimates. Lines 117-119 columns E-I contain the annual rates of enrollment in traditional MaineCare, adjusted by the sensitivity factor.

- Lines 126-137 test the effect of changes in the rate that optional participants would move to Medicaid in those estimates. The analysis estimates that 100% of optional members would move to Medicaid.

Model Disease Transition Probabilities and Spectrum

This sheet shows how quickly HIV infection will progress to AIDS and death, depending on the treatment or lack of treatment provided, There are four scenarios presented using the Markov process disease state transition probabilities in various disease states. The Markov process model is a probabilistic model where each member of a population exists in one state. In the case of HIV infection, the states are "Asymptomatic HIV infection", "Symptomatic HIV infection", "AIDS", and "Death". Death is the final or "absorptive" state. The probabilities on each line state the likelihood that a member in the state will either remain in the state during the period or will progress to one of the other states. Below each state or scenario presented, are distribution numbers which are applied to estimate in the model the number of members in each disease state in each semi-annual period. A period is 6 months. We used semi-annual periods for this analysis, as the original Hopkins published Markov process model was published using semi-annual periods.

Below each scenario presented, is an estimate of the percentage of individuals in each disease state over time based on the application of the probabilistic model. These numbers, combined with current membership and the growth in members for each group in the Model Params tab, result in the estimated actual membership numbers by disease state with and without the waiver in the Model tab . Those numbers are combined with cost information and trended forward with an inflation rate to arrive at the costs for "with" and "without" waiver that ultimately show the budget neutrality for the waiver program.

- The pre-modern therapy probabilities in the first scenario were derived by the HIV group from their clinic experience during the 1990's pre-HAART era. The Hospital's Hopkins probabilities are in cells B10 - F13. Lines 10-13, Columns B-F and I-M contain interpolated transition probabilities used to calculate the effects of loss of the Waiver.

    - Immediately below the pre-modern probabilities, cells B22-F34 estimate the overall distribution of Waiver membership over a 7 year period given the transition probabilities (stated in B10 - F13). These distribution numbers are applied to estimate in the model the number of members in each disease state in each semi-annual period. In essence, this represents progression from HIV infection to death without the provision of effective treatment. Of the 50% who were identified as having HIV at the beginning of the progression, only 7.1% remain asymptomatic.

- Cells I10-M13 contain the modern with ideal treatment "with-Waiver" probabilities. These probabilities are the same ones used in our original model. These probabilities were originally derived from the clinic experience of the Maine Medical Center Viral Treatment Center, which has the largest HIV clinical practice in Maine. We have confirmed them from our waiver experience.

    - This scenario in cells I22-M34 represents the progression from infection with HIV to death with the provision of waiver services. In the 7 year progression in the model, of the 50% who began waiver services asymptomatic of HIV infection, 39.2% remain asymptomatic. This is the most positive outcome of the four scenarios.

- Cells B41-F44 represents an estimate of the effect on disease progression because of the loss of HIV care management on Waiver members who would remain on MaineCare in the absence of the Waiver. We used a 20% linear interpolation between the Hopkins model and the Maine modern-era model to estimate this effect.

    - In this scenario, cells B52-F64 demonstrate that without the care management provided through the waiver program, only 28.4% of the 50% who were identified at the beginning of the disease progression model continue to be asymptomatic of HIV infection after 7 years.

- Cells I41-M44 represents an estimate of the effect on disease progression because of the loss of the Waiver on Waiver enrollees who would lose MaineCare benefits in the absence of the Waiver. We used a 50% linear interpolation between the Hopkins model and the Maine ideal treatment model to estimate this effect.

- In this scenario, cells I52-M64 show that without MaineCare or waiver care management, only 17.2% of the 50% who were identified at the beginning of the disease progression model continue to be asymptomatic of HIV infection after 7 years. This is better than the rate of disease progression without effective treatment, but not as good as outcomes with Medicaid services. Also, as these individuals become ill more quickly, their care will be more expensive sooner to Medicaid. But, if they have the limited package of services provided through the waiver and are able to remain asymptomatic for a longer time, they are less costly and able to lead healthier productive lives.

Model PMPM's (Per-member-per-month Costs)

This sheet contains the per-member-per-month costs of care of the Enrollees and MaineCare members. The costs are calculated as the average of the program and disease state specific costs of care from state fiscal year 2008 through 2012 and trended forward 3 years to account for healthcare inflation.

Premiums

This sheet contains calculations for net premium yield. This figure is used to offset the overall cost of care of the Enrollee group because of the income-related premiums paid by the Enrollee population.

The table from Lines A12-E25 shows the average per-member-per-month premium yield for the Enrollees during each Waiver extension semi-annual period. The premium is inflated by the expected PMPM inflation rate used in the model. This figure is reflected in the WW estimate for the cost of the Enrollee population.

Model

This sheet contains the heart of the cost neutrality model.

Although the Waiver extension application is for three years, we have carried out our model calculations to 6 1/2 years, with an extra period for the third half of DY11(June-Dec 2013), in order to demonstrate the increasing cost effectiveness of effective treatment of HIV over time.

- Lines 5 and 39 show the membership numbers from the "Parameters and Sensitivity" sheet. Lines 6-18 and 37-52 show the disease-state-specific membership for each subsequent semi-annual period over six and a half years. Those membership numbers are calculated using the equation

  Membership in disease state X during period N

  =

  $\sum$ across all disease states (membership in period N -1) * (semi-annual probability of moving from that disease state into disease state X)

  +

  new enrollees in disease state X during period N.

- Lines 22 - 34 and 55-67 show the per-member-per-month costs of care for members in various disease states, as calculated in sheet "PMPM." For Waiver enrollees the costs are net of collected premiums.

- Lines 103-115 and 120-132 show total disease-state-specific costs and overall per-period costs, as calculated by the equation

  Total Period Costs

= (Period Disease-state-specific membership) * (Period disease-state-specific PMPM cost) * 6.

- Lines 116 and 133 show cumulative Waiver extension costs over 6 years.

The sheet shows two scenarios, a With-Waiver (WW) and a Without-Waiver (WOW), for the Enrollee and MaineCare group. Note that the Without Waiver Enrollee-No Coverage group is shown as part of the no-Waiver scenario to clarify the cohort of Enrollees who would be without healthcare coverage in the absence of the Waiver, and to proof the model membership totals between the with-Waiver and the without-Waiver scenarios.

Budget

This sheet shows a proposed year-by-year and total budget for the Enrollee and MaineCare groups for the Waiver extension. Lines 8-15 show the annual and total proposed budgets as developed in the cost-neutrality model.

IV. Analysis of Budget Neutrality

Maine has focused on early treatment and enrollment in the Waiver. This strategy has paid off. Based on an algorithmic method to assign a "disease status" score to each Wavier member/enrollee, same-member comparisons between the first and latest disease stage show a slight overall improvement in disease stage. Our findings show the disease status of individual members and enrollees has been virtually arrested over the course of the Waiver.

We restaged members every year based upon CD4 counts or AIDS-defining illnesses. Same-member comparisons between the first and latest disease stage show a slight overall improvement in disease stage. This indicates that the progression of illness is being arrested under the Waiver Program.

In SFY 2012, about 60% of costs were from enrollees and 40% were from members. It is important to note that in 2012, there were changes made to the algorithm that determines Medicaid Members that resulted in a drop in the Mainecare population by about 100 members. The trend seen before 2012 shows that the costs for enrollees and members had started to even out. Per-member-per month trends shows that even though enrollees account for 60% of costs, they are costing less per member.

MaineCare members must meet disability requirements. Therefore, their disease progression is generally more advanced than the Waiver Enrollees who usually enter the program earlier. We found that the cost of care for Enrollees is about 1/2 to 3/4 of the cost of care for HIV-positive MaineCare members. The enrollees we serve through

the Waiver are the ones who are staying more healthy and living more productive lives than those with full-blown AIDS.

Without the Waiver, individuals would have to wait until their AIDS is full-blown and they are totally disabled to qualify for MaineCare. The "waiting period" would create a lack of continuity of care and result in a sicker population because the enrollees have incomes less than 250% and could not afford HIV medical care. Failure to provide continuous coverage for HIV care is very likely to cause members to get sicker with higher overall costs in the long term. The Waiver allows us to eliminate that gap and gives enrollees a targeted range of continuous health care to prevent and delay the onset of late stage AIDS which is highly expensive to treat. As important, it allows individuals to be functioning members of the community.

A second point is that Waiver enrollment has continued to parallel but not exceed the growth of HIV infection in Maine. In fact, Waiver enrollment as a percentage of HIV infected individuals has continually decreased since 2009 (also impacted by the 100 member drop caused by the change to the Medicaid Algorithm). For this reason, we have anticipated a slight increase in growth over the average for the past few years. We have tracked data from the Maine CDC on overall HIV infection rate in Maine and compared that data with Waiver program membership. In the years between 2003 and 2011, the Maine HIV infection rate grew at an average annual rate of 7.3%. During the years 2003 to 2012, the Waiver program membership grew at an average annual rate of 4.2%. The Enrollees group grew at an average annual rate of 13.5%, while the MaineCare group decreased at an average annual rate of -4.2%.

The State has developed and implemented a comprehensive quality assurance monitoring plan that we use to measure and analyze the operation of the Waiver. We have taken actions such as increasing the awareness of our Nurse Coordinator who was hired specifically to coordinate the HIV Waiver. One of the primary roles of the HIV/AIDS Nurse Coordinator has been to establish a close link with providers' offices to obtain disease progression data including CD4 counts and viral load information that allows her to target interventions to avert and prevent rather than trying to remediate the effects of HIV/AIDS, including the increased costs of serving individuals who have full-blown AIDS. The Nurse Coordinator sends out reminder letters each month by birthday, reminding members/enrollees to get the regular testing they need based on age, sex and condition state of their disease, which will further enhance health while keeping long-term costs of care as low as possible.

We have maintained an extensive ongoing database that includes elements such as all healthcare service claims; complete pharmacy claims data including drug dispensed, days of therapy, and prescription charges and costs to MaineCare; CD4 count and viral load testing data; surveys; and contacts with the member/enrollee. We also track per-member-per-month costs of healthcare services and drugs; compliance with Waiver cost caps; disease status and disease progression; and treatment for opportunistic infections. For the full ten years (2003-2012), we have reported actual pharmaceutical data, which represents over half of the total Waiver costs.

The original Waiver application surmised that early-stage care for HIV infection is not only cost-effective in terms of benefit received for costs incurred, but is fully cost neutral because of avoided costs of care for late-term HIV infection. The experience of the MaineCare HIV Waiver fully supports that claim.

Maine Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS Transition Plan for 2014

Introduction

The Affordable Care Act began improving access to health coverage in 2010. Improvements such as prohibiting insurers from denying coverage to children living with HIV/AIDS and the disallowance of lifetime caps on insurance benefits have provided an important bridge to significant changes to come in 2014. Pending final decision from Maine's administration, Maine has developed two options both of which include renewing the existing 1115 Demonstration Waiver, which is due to expire December 31, 2013. This document describes Maine's vision of coverage for individuals living with HIV/AIDS in 2014.

Current Coverage

Maine currently covers individuals living with HIV/AIDS under Medicaid who have an income equal to or less than 100% of the Federal Poverty Level (FPL). In addition, since 2002 Maine has had a Section 1115 Demonstration Waiver which has covered individuals with gross incomes between 101% and 250% FPL. The goal of the Waiver is to provide more effective and earlier treatment to prevent, reverse, or delay disease progression. The Waiver includes a comprehensive package of services including: hospital, physician, laboratory, behavioral health, transportation, case management, and pharmacy services. The Waiver has allowed Maine to improve access to continuous health care services, assisted in enhancing compliance with treatment and slowed the progression of HIV/AIDS status.

2014 Option 1

Medicaid Expansion and Continued Waiver Coverage

The ACA expands mandatory Medicaid eligibility to all individuals under age 65 with incomes up to 133% FPL. Maine envisions enrolling around 60% of the current 1115 Demonstration Waiver enrollees into Medicaid as newly eligible members. Almost all of the services generally identified as requirements in an essential health benefits package are already provided under the Waiver and would be included in a benchmark plan for the newly eligible members. If Maine establishes a minimal bench mark plan members that move from the Waiver to the Medicaid expansion may see a change in their benefit package. There are some services that this population currently receives under the Waiver that are not fully covered by essential health benefits. Examples of these services include: transportation and case management.

The state of Maine is working on submitting a renewal to the Center for Medicare and Medicaid Services for its 1115 Waiver to continue to cover individuals with incomes that fall between 133% and 250% FPL (estimated to be around 40% of the current membership). The Waiver is up for reauthorization in December 2013. Since these members have incomes greater than 133% FPL they will not automatically become eligible for the Medicaid expansion however they will be able to continue their coverage through the renewal of this Waiver.

2014 Option 2

In the event that the state of Maine does not participate in the Medicaid expansion, this Waiver will allow for continuation of all covered Waiver services to the qualified HIV/AIDS members.

Therefore Maine will submit a renewal for the existing 1115 Waiver. If the expansion does not occur, the Waiver will ensure the availability of continued coverage for individuals with incomes between 101% - 250% FPL. Members with incomes under 100% FPL will continue to receive coverage through full Medicaid as they currently do.

Conclusion

Since Maine is pending final decisions from the administration, Maine has developed two options for our transition into 2014. By renewing the 1115 Waiver, it ensures that Maine's HIV/AIDS population will have sufficient coverage with either of the above outcomes. If the Medicaid expansion occurs, we will transition around 60% of the current Waiver population into Medicaid and will continue the Waiver for the other 40%. If the Medicaid expansion does not occur, Maine will continue to provide coverage through the 1115 Waiver and members with incomes at or below 100% FPL will continue receiving services through full Medicaid.

HIV/AIDS 1115 Demonstration Waiver Draft Evaluation Design

In 2002, Maine's Medicaid program, MaineCare, was granted a five year 1115 demonstration waiver from CMS which would provide a broad range of healthcare services to Maine citizens living with HIV infection. Services include: physician services, outpatient laboratory and radiology, prescription medications, inpatient and outpatient hospital services, mental health and substance abuse services, and case management. The goal of this demonstration is to delay, prevent, or reverse the progress of HIV/AIDS by providing comprehensive and affordable access to treatment in the early stages of illness. This demonstration began on July 1, 2002 and has since received two extensions, one through June 30, 2010 and the second through December 31, 2013.

The evaluation of the demonstration will enable the Department of Health and Human Services the opportunity to review the trends and disease stage progression. Review of treatment for acute to chronic HIV infections will determine if interventions were successful. We will review:

- Demographic trends of HIV infection in Maine
- Waiver enrollee and membership demographic trends
- Disease status and progression trends
- Per member cost trends
- Trends from treatment of acute to chronic HIV infection, from treatment of the primary infection to treatment of the complications of long-term-treatment, and of aging
- Comparison of actual experience to our projections
- Overall cost neutrality

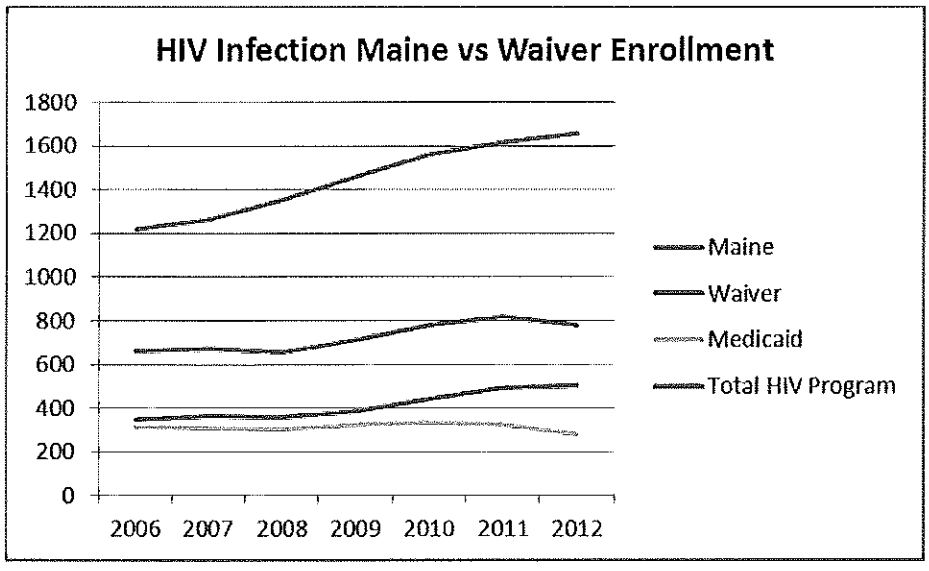
Demographic trends of HIV infection in Maine and for waiver enrollees

Identify trends of HIV infection in Maine including: gender, race/ethnicity, age, exposure category/risk behavior, socioeconomic status and clients served by Ryan White and the AIDS Drug Assistance Program.

Identify trends in MaineCare HIV demonstration enrollee counts by utilizing an algorithm based on diagnoses provided with healthcare service claims and prescriptions filled for anti-retroviral drugs. Monitor expenditures to ensure we spend to cap to determine if a waiting list needs to be implemented.

HIV Infection in Maine 2001-2011

Year	Residents Living with HIV Infection	Growth Rate	Number of New Cases
2001	775		
2002	855	10%	80
2003	943	10%	88
2004	1027	9%	84
2005	1144	11%	117
2006	1217	6%	73
2007	1264	4%	47
2008	1355	7%	91
2009	1462	8%	107
2010	1563	7%	101
2011	1616	3%	53
9-Year Average		**7.3%**	84

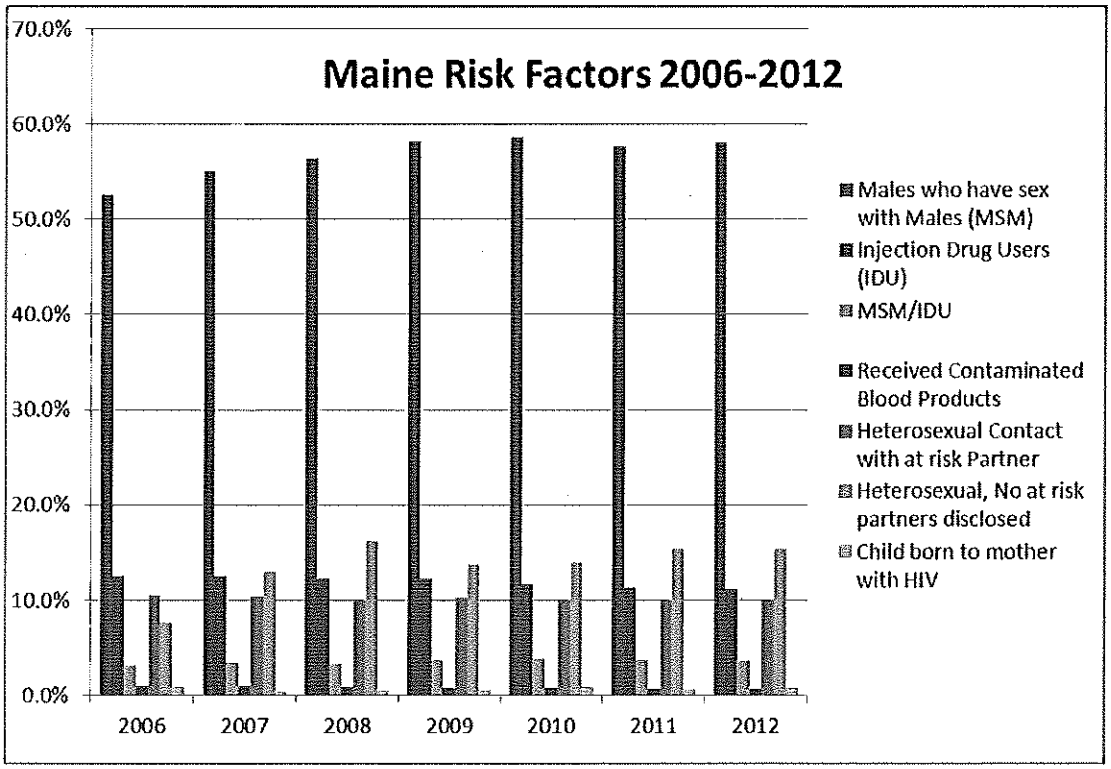


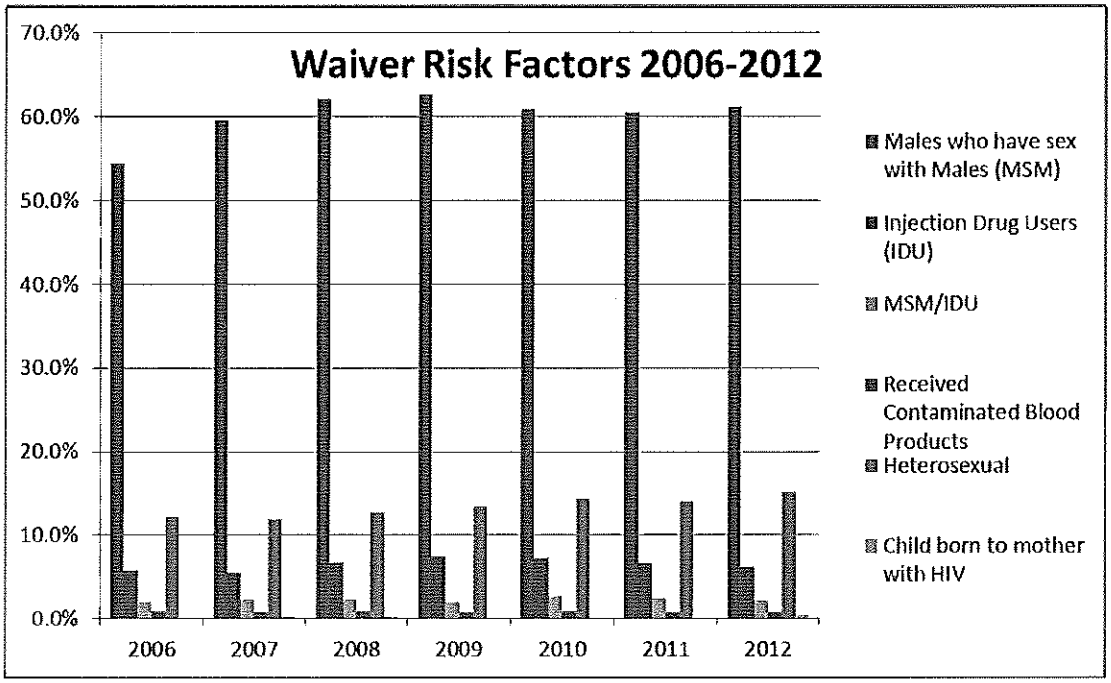
On average, the total HIV Program Enrollment encompasses about 50% of the total known infected. The waiver itself covers about 30% of the total known infected, on average. Waiver enrollment continues to grow on an average of about 7% per year. The rate of known HIV positive people in Maine grew an average of about 5% per year. This

means that the rate of incoming waiver members is faster than the rate of growth in HIV infection for people living in Maine (2006-2012).

Enrollment Totals	2006	2007	2008	2009	2010	2011	2012
Maine	1217	1264	1355	1462	1563	1616	1654
Waiver	347	364	357	389	442	496	504
Medicaid	315	308	302	325	337	324	278
Total HIV Program	662	672	659	714	779	820	782

Percent Change - Enrollment	2006	2007	2008	2009	2010	2011	2012
Maine		4%	7%	8%	7%	3%	2%
Waiver		5%	-2%	9%	14%	12%	2%
Medicaid		-2%	-2%	8%	4%	-4%	-14%
Total HIV Program		2%	-2%	8%	9%	5%	-5%

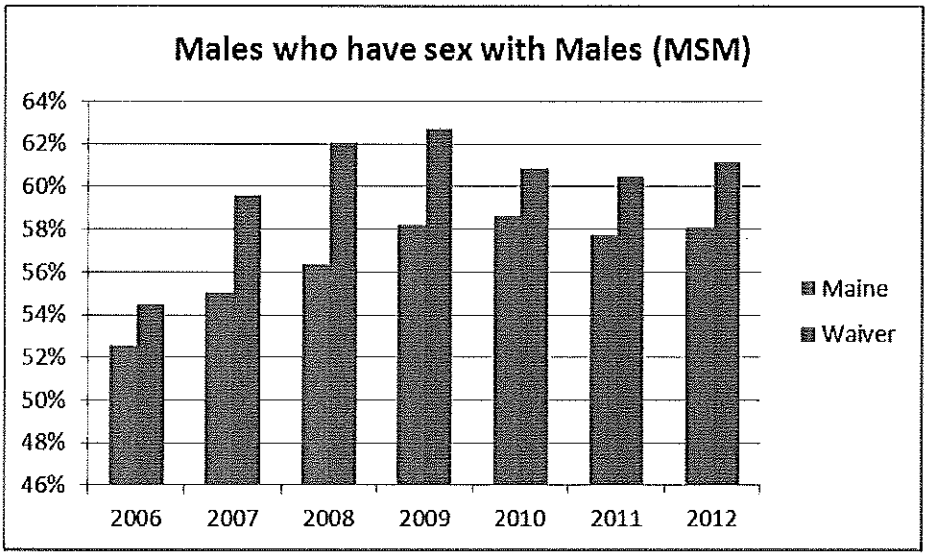




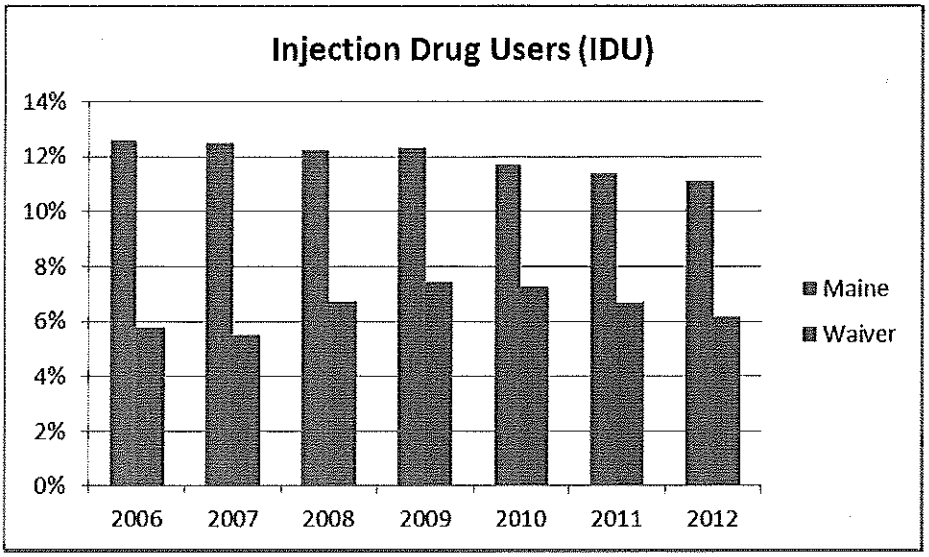
The MSM risk factor continues to be the leading cause of HIV infection for both HIV positive people living in Maine and waiver enrollees, accounting for over 50% of the infected. The next most common risk factor for both HIV positive people living in Maine and waiver enrollees, is heterosexual (with or without an at risk partner) followed by IDU. Other risk factors were present at very low levels.

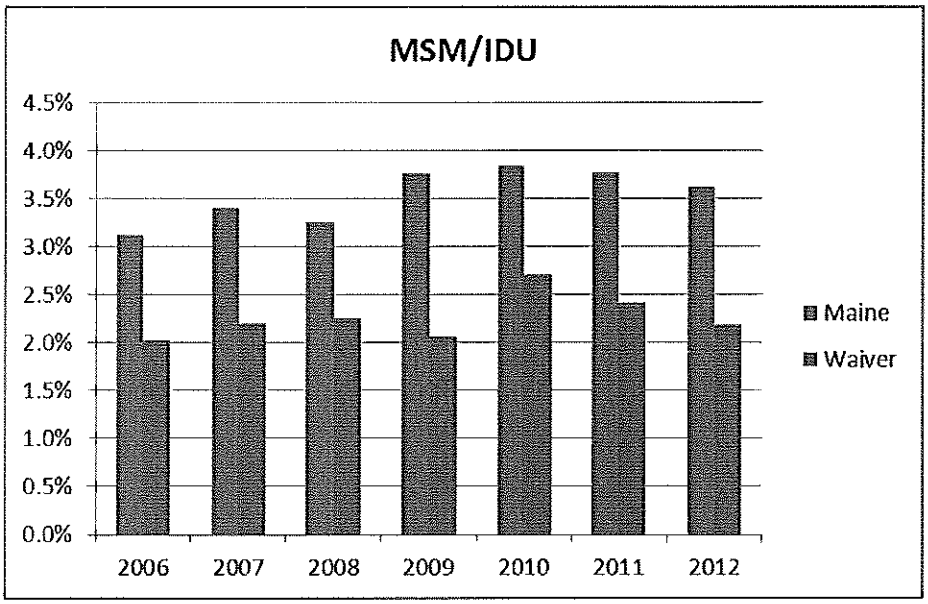
MAINE	2006	2007	2008	2009	2010	2011	2012
Males who have sex with Males (MSM)	52.6%	55.1%	56.4%	58.2%	58.6%	57.7%	58.1%
Injection Drug Users (IDU)	12.6%	12.5%	12.3%	12.3%	11.7%	11.4%	11.1%
MSM/IDU	3.1%	3.4%	3.2%	3.8%	3.8%	3.8%	3.6%
Received Contaminated Blood Products	1.1%	1.0%	0.9%	0.8%	0.8%	0.7%	0.7%
Heterosexual Contact with at risk Partner	10.5%	10.4%	10.0%	10.3%	10.0%	10.0%	10.0%
Heterosexual, No at risk partners disclosed	7.7%	13.1%	16.2%	13.7%	14.0%	15.4%	15.4%
Heterosexual Total	18.2%	23.4%	26.2%	24.1%	24.1%	25.4%	25.5%
Child born to mother with HIV	0.9%	0.5%	0.5%	0.5%	0.9%	0.6%	0.7%
Undetermined	11.5%	4.1%	0.5%	0.3%	0.1%	0.4%	0.3%

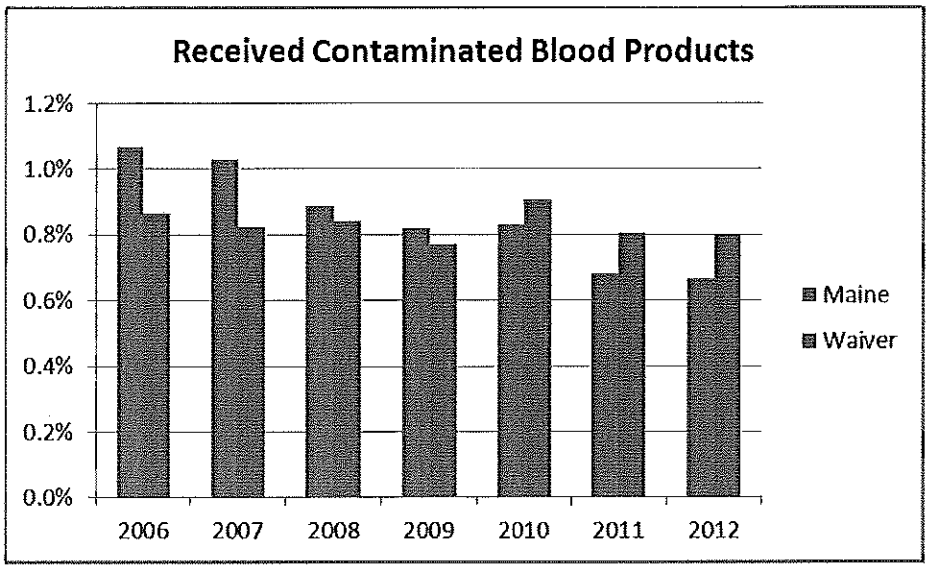
WAIVER	2006	2007	2008	2009	2010	2011	2012
Males who have sex with Males (MSM)	54.5%	59.6%	62.1%	62.7%	60.9%	60.5%	61.2%
Injection Drug Users (IDU)	5.8%	5.5%	6.7%	7.5%	7.2%	6.7%	6.2%
MSM/IDU	2.0%	2.2%	2.2%	2.1%	2.7%	2.4%	2.2%
Received Contaminated Blood Products	0.9%	0.8%	0.8%	0.8%	0.9%	0.8%	0.8%
Heterosexual	12.1%	11.8%	12.6%	13.4%	14.3%	14.1%	15.1%
Child born to mother with HIV	0.0%	0.3%	0.3%	0.0%	0.0%	0.0%	0.4%
Undetermined	24.8%	19.8%	15.2%	13.6%	14.0%	15.5%	14.1%

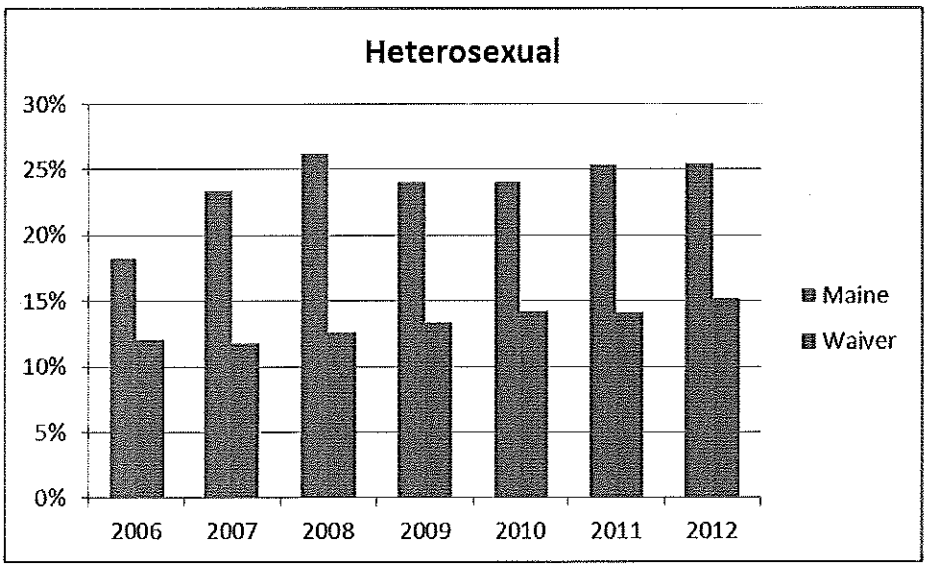


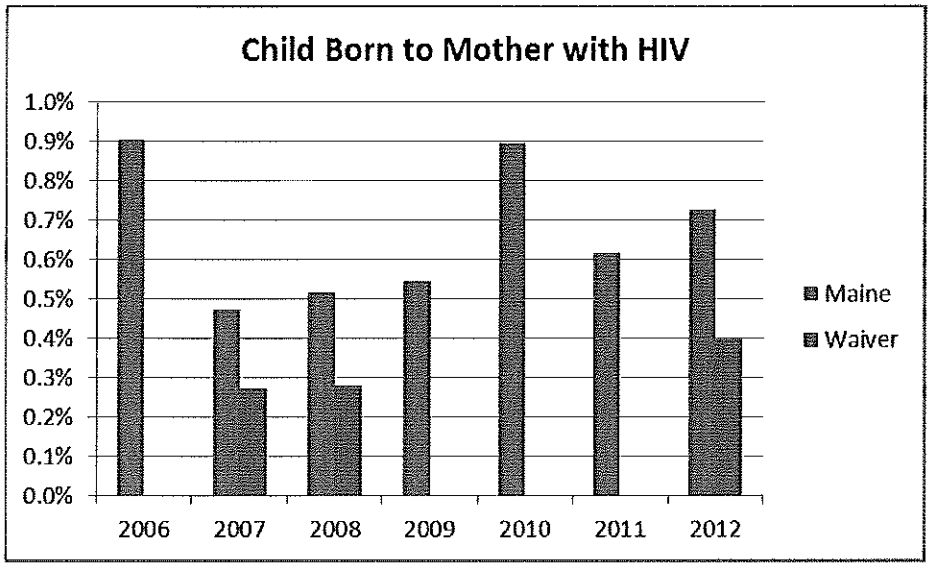
Over a 7 year time period (2006-2012), MSM has continued to be the most common risk factor for HIV positive people. On average, 60% of people on the waiver had an MSM risk factor, comparerd to about a 50% average for all people living with HIV in Maine. The waiver has a slightly higher percetage of members with MSM risk factors than the total infected, therefore the waiver has enrolled slightly more of the people with an MSM risk factor than people with different risk factors. The percentage of people with an MSM risk factor continually increased, peaking in 2009 for waiver enrollees (63%), and 2010 for the total infected in Maine (59%). The percentage then decreased slightly, and began to increase in 2012 at a slower rate than was seen between 2006-2009/2010.

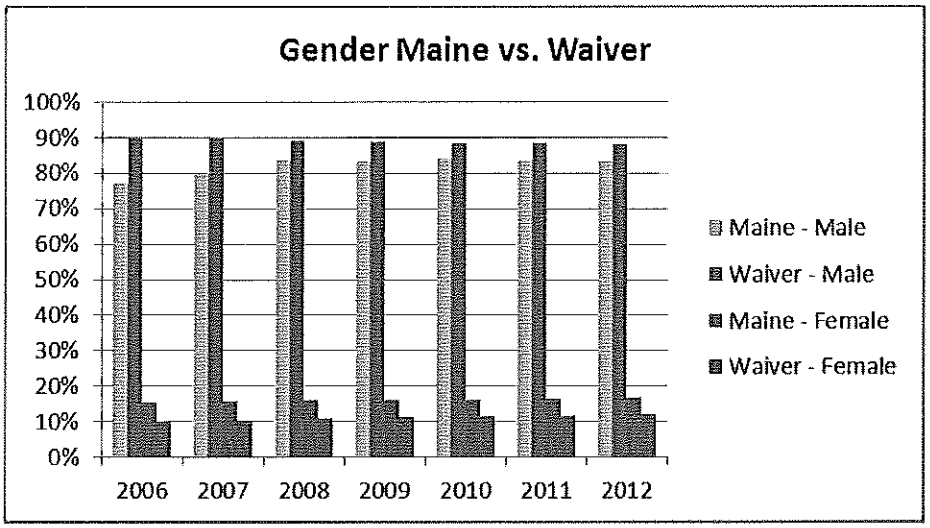

Injection Drug Users (IDU)
14%
12%
10%
8%
6%
4%
2%
0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver


MSM/IDU
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver

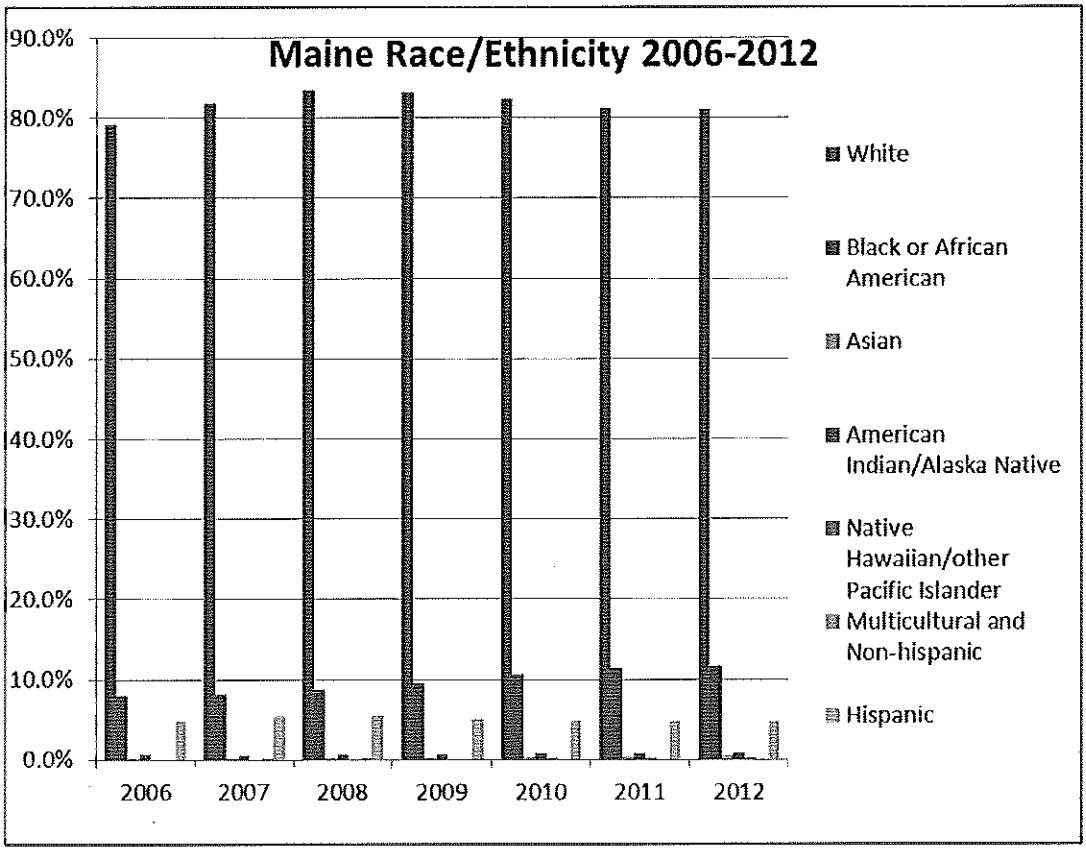

Received Contaminated Blood Products
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver

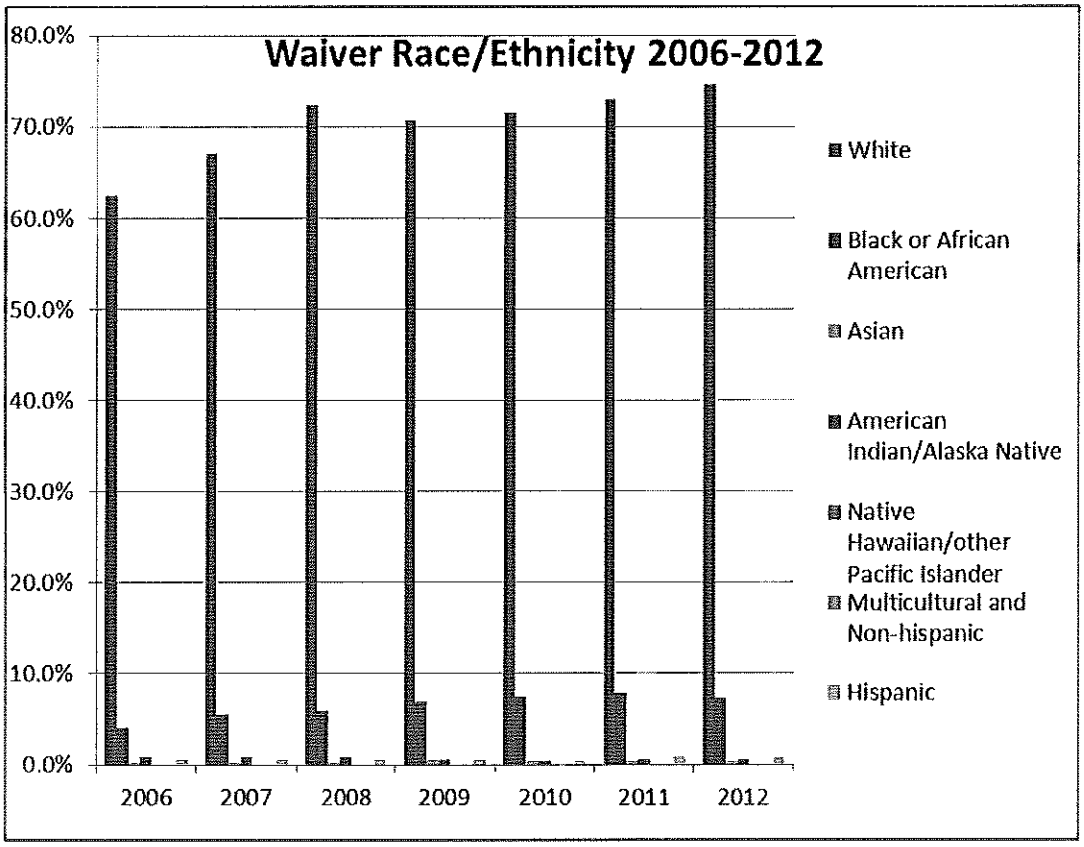

Heterosexual
30%
25%
20%
15%
10%
5%
0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver

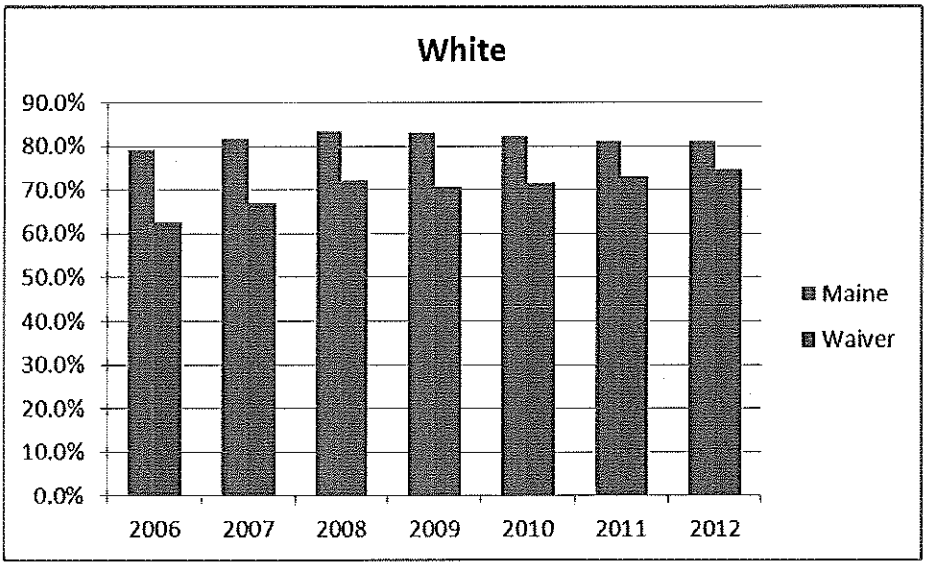


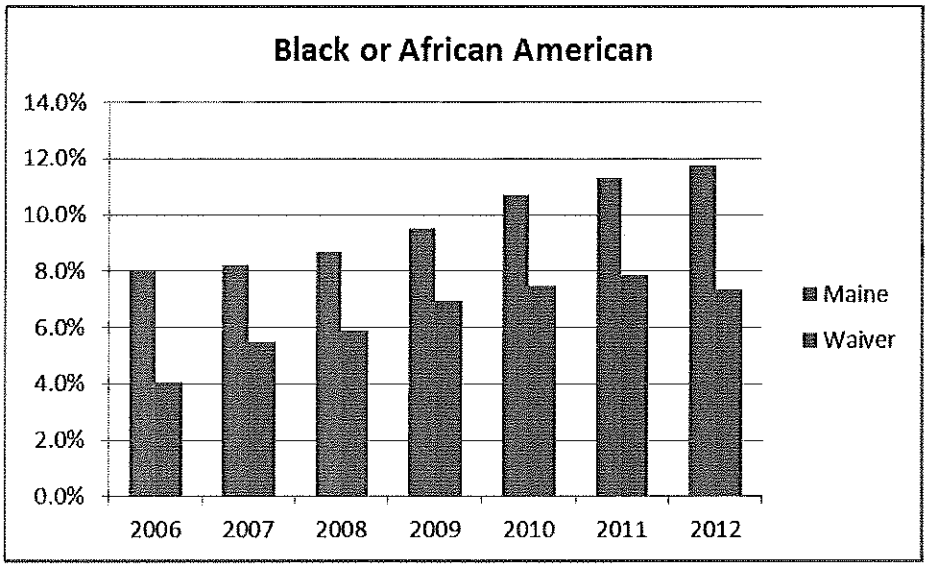


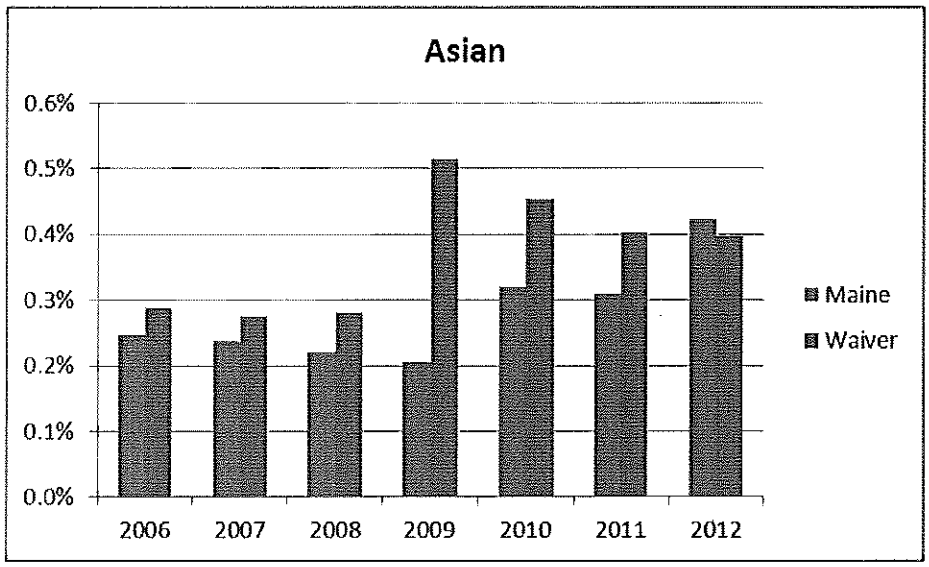
Gender	2006	2007	2008	2009	2010	2011	2012
Waiver - Male	90.2%	89.8%	89.1%	88.7%	88.2%	88.3%	87.9%
Waiver - Female	9.8%	10.2%	10.9%	11.3%	11.8%	11.7%	12.1%
Maine - Male	77.2%	80.2%	83.7%	83.4%	83.8%	83.5%	83.1%
Maine - Female	15.4%	15.8%	16.0%	16.2%	16.2%	16.5%	16.9%
Maine - Unknown	7.4%	4.0%	0.3%	0.4%	0.0%	0.0%	0.0%

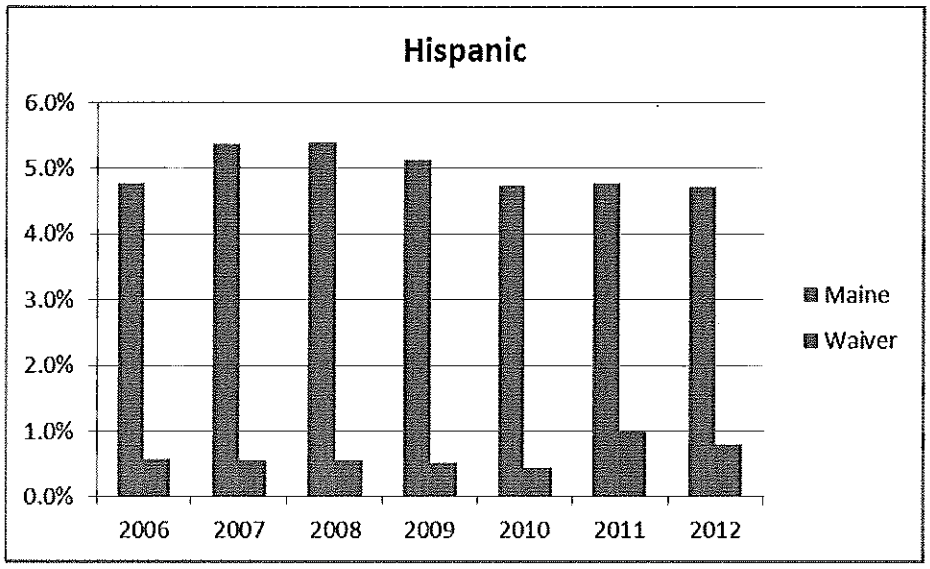

Maine Race/Ethnicity 2006-2012
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
White
Black or African American
Asian
American Indian/Alaska Native
Native Hawaiian/other Pacific Islander
Multicultural and Non-hispanic
Hispanic

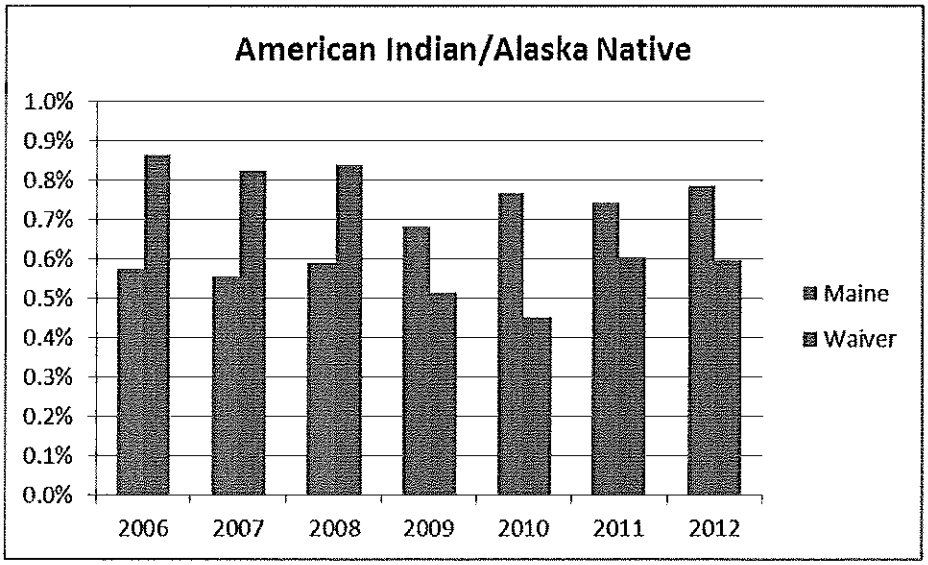

Waiver Race/Ethnicity 2006-2012
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
White
Black or African American
Asian
American Indian/Alaska Native
Native Hawaiian/other Pacific islander
Multicultural and Non-hispanic
Hispanic


White
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver


Black or African American
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver


Asian
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
2006
2007
2008
2009
2010
2011
2012
Maine
Waiver

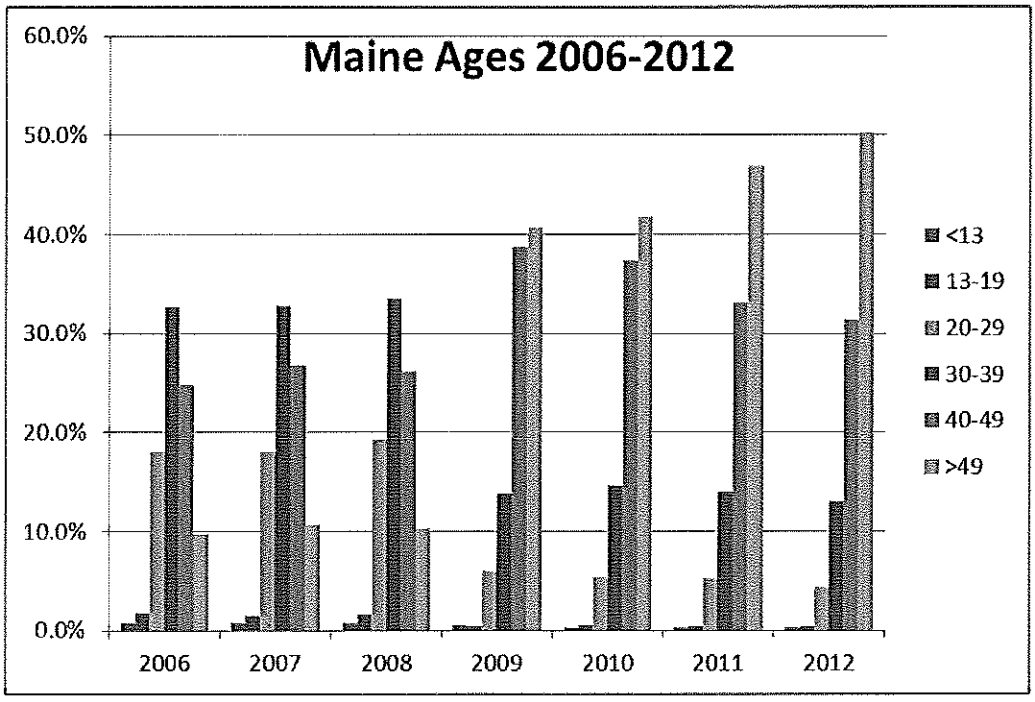


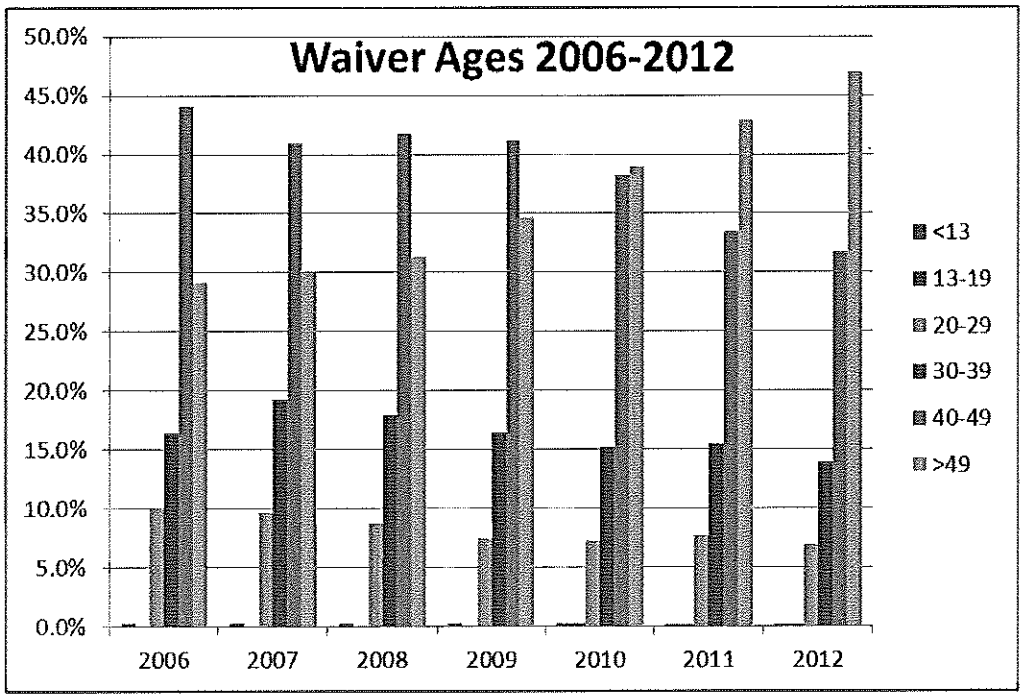


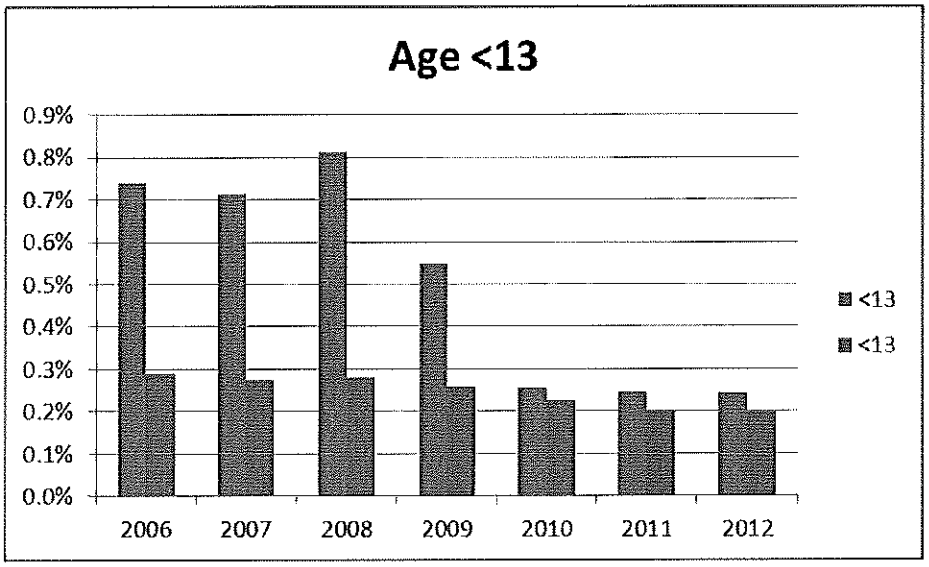
Maine	2006	2007	2008	2009	2010	2011	2012
White	79.1%	81.7%	83.5%	83.1%	82.3%	81.1%	81.1%
Black or African American	8.0%	8.2%	8.7%	9.5%	10.7%	11.3%	11.7%
Asian	0.2%	0.2%	0.2%	0.2%	0.3%	0.3%	0.4%
American Indian/Alaska Native	0.6%	0.6%	0.6%	0.7%	0.8%	0.7%	0.8%
Native Hawaiian/other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
Multicultural and Non-hispanic	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%

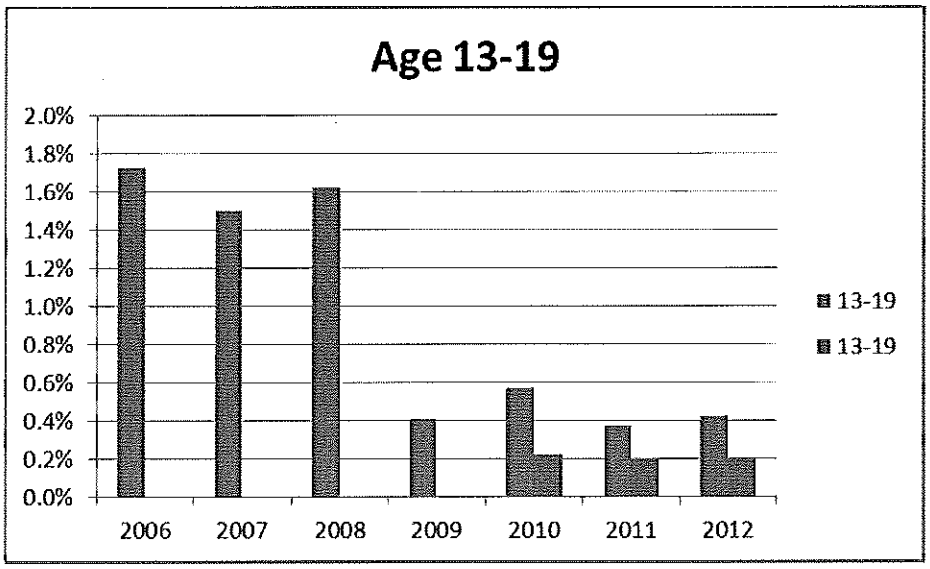
Hispanic	4.8%	5.4%	5.4%	5.1%	4.7%	4.8%	4.7%
Unknown	7.3%	3.7%	1.5%	1.4%	1.1%	1.7%	1.2%

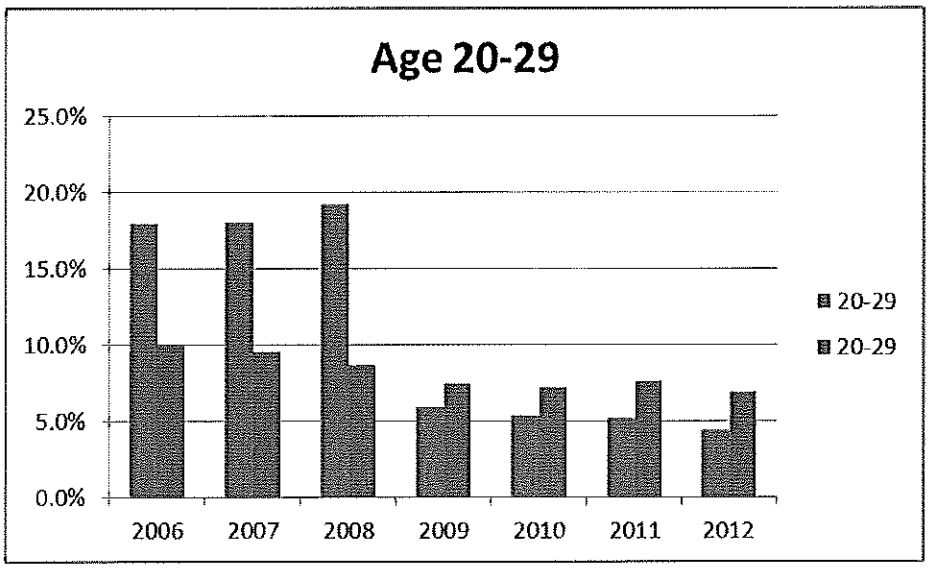
Waiver	2006	2007	2008	2009	2010	2011	2012
White	62.5%	67.0%	72.3%	70.7%	71.5%	73.0%	74.6%
Black or African American	4.0%	5.5%	5.9%	6.9%	7.5%	7.9%	7.3%
Asian	0.3%	0.3%	0.3%	0.5%	0.5%	0.4%	0.4%
American Indian/Alaska Native	0.9%	0.8%	0.8%	0.5%	0.5%	0.6%	0.6%
Native Hawaiian/other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Multicultural and Non-hispanic	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Hispanic	0.6%	0.5%	0.6%	0.5%	0.5%	1.0%	0.8%
Unknown	31.7%	25.8%	20.2%	20.8%	19.7%	17.1%	16.3%

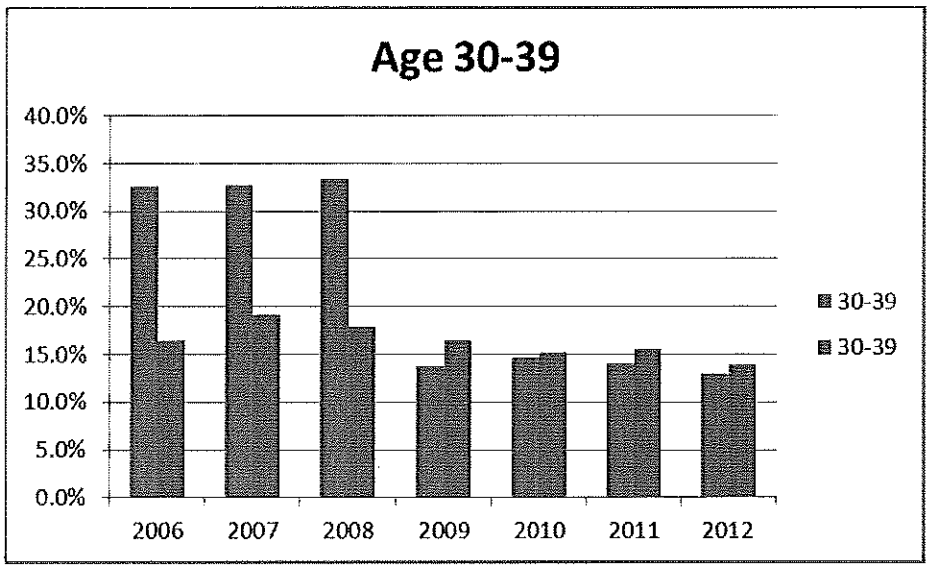


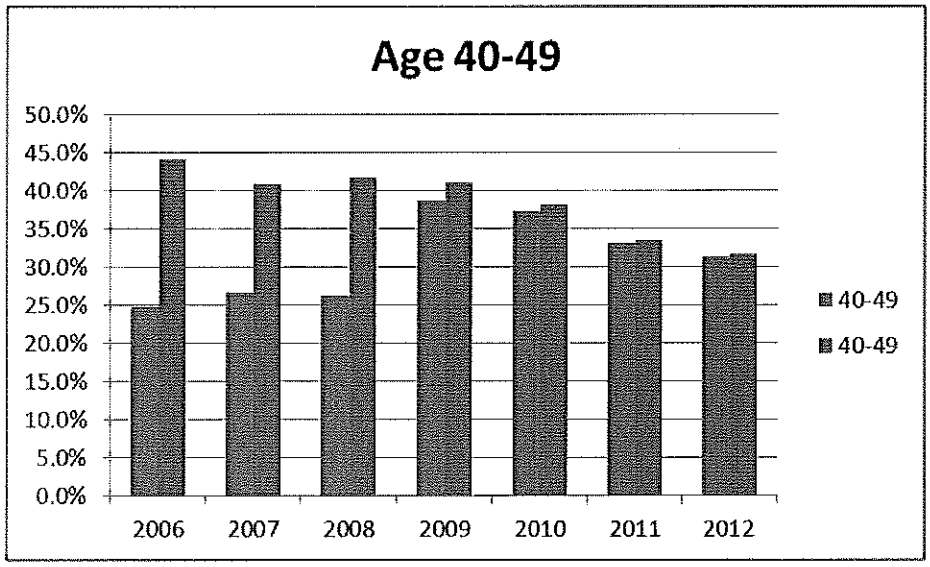

Waiver Ages 2006-2012
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
<13
13-19
20-29
30-39
40-49
>49

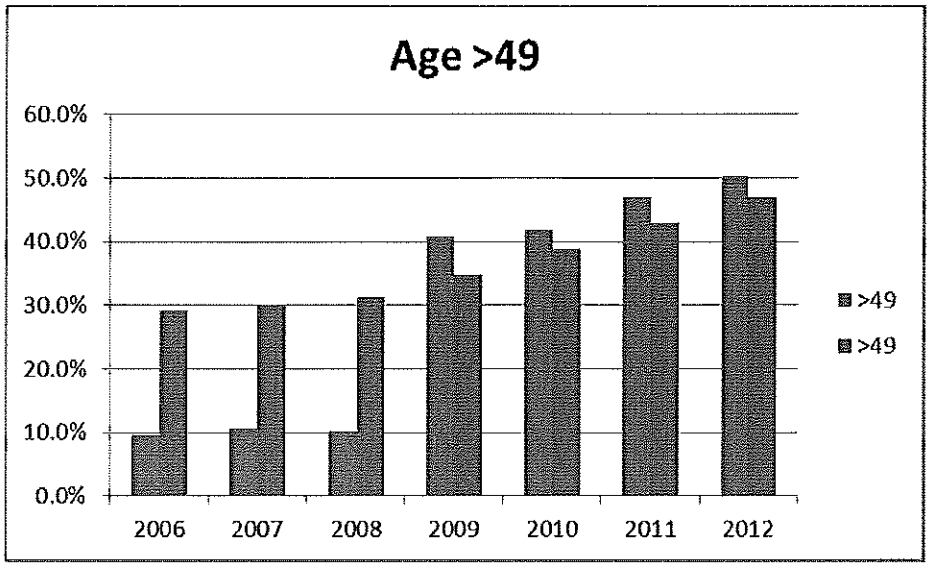

Age <13
0.9%
0.8%
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
2006
2007
2008
2009
2010
2011
2012
<13
<13


Age 13-19
2.0%
1.8%
1.6%
1.4%
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
2006
2007
2008
2009
2010
2011
2012
13-19
13-19


Age 20-29
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
20-29
20-29


Age 30-39
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
30-39
30-39


Age 40-49
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2006
2007
2008
2009
2010
2011
2012
40-49
40-49



Maine	2006	2007	2008	2009	2010	2011	2012
<13	0.7%	0.7%	0.8%	0.5%	0.3%	0.2%	0.2%
13-19	1.7%	1.5%	1.6%	0.4%	0.6%	0.4%	0.4%
20-29	18.0%	18.0%	19.3%	6.0%	5.4%	5.3%	4.4%
30-39	32.6%	32.8%	33.4%	13.7%	14.7%	14.0%	13.0%
40-49	24.8%	26.7%	26.2%	38.6%	37.4%	33.1%	31.4%
>49	9.7%	10.7%	10.3%	40.7%	41.8%	46.9%	50.2%
unknown	12.4%	9.6%	8.4%	0.0%	0.0%	0.1%	0.3%

Waiver	2006	2007	2008	2009	2010	2011	2012
<13	0.3%	0.3%	0.3%	0.3%	0.2%	0.2%	0.2%
13-19	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%	0.2%
20-29	10.1%	9.6%	8.7%	7.5%	7.2%	7.7%	6.9%
30-39	16.4%	19.2%	17.9%	16.5%	15.2%	15.5%	13.9%
40-49	44.1%	40.9%	41.7%	41.1%	38.2%	33.5%	31.7%
>49	29.1%	29.9%	31.4%	34.7%	38.9%	42.9%	47.0%

Most years, we have been under the cap and cumulatively, about $34 million under the budget cap. We will not have to implement a waiting list.

Demonstration Year and State Fiscal Year	Actual Costs (from quarterly financial shell)	Actual Savings
DY01 - SFY2003	$5,082,027	$3,624,029
DY02 - SFY2004	$7,726,644	$2,516,548
DY03 - SFY2005	$7,313,399	$4,445,299
DY04 - SFY2006	$9,421,347	$3,808,392
DY05 - SFY2007	$7,881,027	$6,752,843
DY06 - SFY2008	$8,994,605	($183,344)
DY07 - SFY2009	$9,093,802	$2,489,175
DY08 - SFY2010	$9,168,200	$5,121,033
DY09 - SFY2011	$9,746,487	$1,435,007
DY10 - SFY2012	$10,361,665	$4,110,988

Cumulative Savings DY01 - DY10 **$34,119,971**

Disease status and progression trends

Identify death rates among demonstration enrollees; compare to national rates. Measurement of clinical health status in HIV infected people by analyzing their CD4 count and their viral load test measures. Determine if interventions are working by analyzing progression from asymptomatic to symptomatic to AIDS.

State Fiscal Year 2003	State Fiscal Year 2004	State Fiscal Year 2005
3	2	3
12	9	14
15	11	17
State Fiscal Year 2006	State Fiscal Year 2007	State Fiscal Year 2008
0	5	6
11	13	17
11	18	23
State Fiscal Year 2009	State Fiscal Year 2010	State Fiscal Year 2011
2	4	8
6	5	10
8	9	18

State Fiscal Year 2012	
4	Demonstration Enrollees
7	Medicaid Members
11	Total

SFY	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	3	2	3	0	5	6	2	4	8	4
Waiver Members	142	173	210	322	359	364	369	420	475	502

On average, 1% of waiver enrollees die each State Fiscal Year.

National Death Rates: Deaths/Total Diagnosed (55%)
1,155,792 people in the United States have been diagnosed with AIDS.
Approximately 636,000 people in the United States with an AIDS diagnosis have died since the epidemic began.

Rate of progression from stage to stage: A higher percentage of waiver enrollees stay in the asymptomatic and symptomatic stages than people who do not have the waiver. Those people not on the waiver progress to the high cost AIDS stage and eventually death.

Disease Progression with Waiver Services

Initial Disease Spectrum	50%	25%	25%		
Period (6 months)	Asx	Sx	AIDS	Deaths	Total
1	50.0%	25.0%	25.0%	0.0%	100.0%
2	49.0%	25.3%	25.1%	0.6%	100.0%
3	48.0%	25.5%	25.2%	1.3%	100.0%
4	47.1%	25.7%	25.4%	1.9%	100.0%
5	46.1%	25.9%	25.5%	2.5%	100.0%
6	45.2%	26.1%	25.6%	3.2%	100.0%
7	44.3%	26.2%	25.7%	3.8%	100.0%
8	43.4%	26.4%	25.8%	4.4%	100.0%
9	42.5%	26.5%	25.9%	5.1%	100.0%
10	41.7%	26.6%	26.0%	5.7%	100.0%
11	40.9%	26.7%	26.1%	6.4%	100.0%
12	40.0%	26.8%	26.2%	7.1%	100.0%

Disease Progression with No Effective Treatment

Initial Disease Spectrum	50%	25%	25%		
Period	Asx	Sx	AIDS	Deaths	Total
1	50.0%	25.0%	25.0%	0.0%	100.0%
2	42.5%	28.3%	27.0%	2.3%	100.0%
3	36.1%	30.4%	28.8%	4.7%	100.0%
4	30.7%	31.6%	30.4%	7.3%	100.0%
5	26.1%	32.2%	31.7%	10.0%	100.0%
6	22.2%	32.1%	32.8%	12.9%	100.0%
7	18.9%	31.7%	33.6%	15.8%	100.0%
8	16.0%	30.9%	34.2%	18.9%	100.0%

9	13.6%	29.9%	34.6%	21.9%	100.0%
10	11.6%	28.7%	34.8%	25.0%	100.0%
11	9.8%	27.4%	34.7%	28.0%	100.0%
12	8.4%	26.0%	34.5%	31.1%	100.0%

Mandatory population with Medicaid services, but no waiver services

Initial Disease Spectrum	50%	25%	25%		
Period	Asx	Sx	AIDS	Deaths	Total
1 - DY11 - 2013 - 2nd half	50.0%	25.0%	25.0%	0.0%	100.0%
2 - DY12 - 2014 - 1st half	47.7%	25.9%	25.5%	1.0%	100.0%
3 - DY12 - 2014 - 2nd half	45.5%	26.6%	26.0%	1.9%	100.0%
4 - DY13 - 2015 - 1st half	43.4%	27.2%	26.4%	2.9%	100.0%
5 - DY13 - 2015 - 2nd half	41.4%	27.8%	26.9%	3.9%	100.0%
6 - DY14 - 2016 - 1st half	39.5%	28.2%	27.3%	4.9%	100.0%
7 - DY14 - 2016 - 2nd half	37.7%	28.6%	27.7%	6.0%	100.0%
8 - DY15 - 2017 - 1st half	36.0%	28.9%	28.1%	7.0%	100.0%
9 - DY15 - 2017 - 2nd half	34.3%	29.2%	28.4%	8.1%	100.0%
10 - DY16 - 2018 - 1st half	32.7%	29.4%	28.7%	9.2%	100.0%
11 - DY16 - 2018 - 2nd half	31.2%	29.5%	29.0%	10.3%	100.0%
12 - DY17 - 2019 - 1st half	29.8%	29.5%	29.3%	11.4%	100.0%
13 - DY17 - 2019 - 2nd half	28.4%	29.5%	29.5%	12.5%	100.0%

Optional population with no waiver or Medicaid services

Initial Disease Spectrum	50%	25%	25%		
Period	Asx	Sx	AIDS	Deaths	Total
1 - DY11 - 2013 - 2nd half	50.0%	25.0%	25.0%	0.0%	100.0%
2 - DY12 - 2014 - 1st half	45.8%	26.8%	26.1%	1.4%	100.0%
3 - DY12 - 2014 - 2nd half	41.9%	28.1%	27.1%	2.9%	100.0%
4 - DY13 - 2015 - 1st half	38.3%	29.2%	28.0%	4.5%	100.0%
5 - DY13 - 2015 - 2nd half	35.0%	30.0%	28.8%	6.1%	100.0%
6 - DY14 - 2016 - 1st half	32.1%	30.5%	29.6%	7.8%	100.0%
7 - DY14 - 2016 - 2nd half	29.3%	30.9%	30.3%	9.5%	100.0%
8 - DY15 - 2017 - 1st half	26.8%	31.0%	30.9%	11.2%	100.0%
9 - DY15 - 2017 - 2nd half	24.6%	31.0%	31.4%	13.0%	100.0%
10 - DY16 - 2018 - 1st half	22.5%	30.8%	31.9%	14.8%	100.0%
11 - DY16 - 2018 - 2nd half	20.6%	30.5%	32.3%	16.7%	100.0%
12 - DY17 - 2019 - 1st half	18.8%	30.1%	32.6%	18.5%	100.0%
13 - DY17 - 2019 - 2nd half	17.2%	29.6%	32.8%	20.4%	100.0%

Year	1 - ASX	2 - SX	3 - AIDS
SFY03	43%	31%	26%
SFY04	44%	31%	26%
SFY05	51%	28%	21%
SFY06	55%	23%	21%

SFY07	57%	24%	18%
SFY08	52%	34%	14%
SFY09	58%	31%	11%
SFY10	49%	41%	10%
SFY11	56%	35%	9%
SFY12	66%	26%	8%

Since the beginning of the waiver, enrollees have increasingly stayed in the asymptomatic stage instead of progressing to the symptomatic stage or AIDS stage. The percent of people in the AIDS stage has continually decreased. From State Fiscal Year 2003-2012, the percentage of enrollees in the asymptomatic stage has increased by 23%, while the enrollees in the symptomatic stage has decreased by 5%, and the enrollees in the AIDS stage has decreased by 18%.

Per member cost trends

Analyze per member costs to MaineCare stratified by disease stage. Analyze utilization and cost of care correlation to member disease stage.

Currently:
PMPM cost of OUR population (Medicaid and Demo) = $1,373

If broken down separately: Demo = $1,073 PMPM & Medicaid = $1,437 PMPM

PMPM cost of MaineCare members with HIV that **aren't** on our program (or care managed) = $1,834 PMPM.

Waiver members account for the lowest PMPM cost.

Waiver Only: Generally, PMPM costs increase when going from one disease stage to the next. Keeping members in the asymptomatic stage decreases the PMPM cost for the waiver. From the previous section, we can see that people on the waiver stay in the asymptomatic stage longer than people who do not have the waiver or effective treatment. At the end of a six year period, 40% of people on the waiver stayed in the asymptomatic stage. Only 8% of people who are not on the waiver and have no effective treatment, remained in the asymptomatic stage. Additionally, only 28% of people who receive Medicaid services but no waiver services remained in the asymptomatic stage.

Sum of Total PMPM	**Column Labels**		
Row Labels	**1 - ASX**	**2 - SX**	**3 - AIDS**
DY01 - SFY03	$ 487.15	$ 933.71	$ 840.73
DY02 - SFY04	$ 686.12	$ 1,128.86	$ 1,404.56
DY03 - SFY05	$ 940.01	$ 846.67	$ 1,240.76

DY04 - SFY06	$ 560.54	$ 713.74	$ 1,135.35
DY05 - SFY07	$ 593.33	$ 850.34	$ 983.15
DY06 - SFY08	$ 849.42	$ 913.70	$ 902.00
DY07 - SFY09	$ 989.65	$ 946.96	$ 882.01
DY08 - SFY10	$ 1,108.76	$ 1,035.10	$ 1,125.44
DY09 - SFY11	$ 956.69	$ 907.16	$ 1,077.18
DY10 - SFY12	$ 1,224.83	$ 1,206.56	$ 1,300.07

Sum of TotCosts	Column Labels			
Row Labels	**1 - ASX**	**2 - SX**	**3 - AIDS**	**Grand Total**
DY01 - SFY03	$ 277,190.24	$ 444,446.31	$ 172,348.85	$ 893,985.40
DY02 - SFY04	$ 537,231.00	$ 628,775.38	$ 412,939.59	$ 1,578,945.96
DY03 - SFY05	$ 908,986.80	$ 590,129.56	$ 326,319.75	$ 1,825,436.11
DY04 - SFY06	$ 946,756.41	$ 571,702.57	$ 493,876.67	$ 2,012,335.65
DY05 - SFY07	$ 1,192,593.57	$ 892,855.43	$ 424,718.93	$ 2,510,167.93
DY06 - SFY08	$ 1,516,207.66	$ 1,298,369.52	$ 227,304.16	$ 3,041,881.34
DY07 - SFY09	$ 2,075,287.57	$ 1,145,825.35	$ 266,367.07	$ 3,487,479.99
DY08 - SFY10	$ 2,278,498.58	$ 1,816,602.83	$ 405,156.92	$ 4,500,258.33
DY09 - SFY11	$ 2,474,952.46	$ 1,530,382.08	$ 479,344.84	$ 4,484,679.38
DY10 - SFY12	$ 3,958,660.00	$ 1,748,312.00	$ 442,022.50	$ 6,148,994.50
Grand Total	**$ 16,166,364.29**	**$ 10,667,401.03**	**$ 3,650,399.27**	**$ 30,484,164.59**

Entire Program:

Sum of Total PMPM	Column Labels		
Row Labels	**1 - ASX**	**2 - SX**	**3 - AIDS**
DY01 - SFY03	$ 1,483.08	$ 2,494.16	$ 2,659.03
DY02 - SFY04	$ 1,915.06	$ 2,624.63	$ 4,055.76
DY03 - SFY05	$ 2,405.52	$ 2,843.29	$ 3,230.50
DY04 - SFY06	$ 1,852.58	$ 2,425.02	$ 3,384.97
DY05 - SFY07	$ 1,769.53	$ 2,149.13	$ 3,101.03
DY06 - SFY08	$ 2,188.28	$ 2,969.38	$ 4,478.94
DY07 - SFY09	$ 2,250.01	$ 2,751.62	$ 3,303.54
DY08 - SFY10	$ 2,286.50	$ 2,302.54	$ 2,694.28
DY09 - SFY11	$ 2,058.93	$ 2,286.54	$ 2,617.41
DY10 - SFY12	$ 2,593.30	$ 3,122.09	$ 3,730.90

Sum of TotCosts	Column Labels			
Row Labels	1 - ASX	2 - SX	3 - AIDS	Grand Total
DY01 - SFY03	$ 1,381,671.76	$ 1,889,426.79	$ 1,854,281.06	$ 5,125,379.60
DY02 - SFY04	$ 2,195,070.21	$ 2,257,667.97	$ 3,034,984.57	$ 7,487,722.75
DY03 - SFY05	$ 3,240,624.44	$ 2,644,652.07	$ 2,162,847.23	$ 8,048,123.74
DY04 - SFY06	$ 3,003,675.32	$ 2,116,994.70	$ 2,633,268.09	$ 7,753,938.11
DY05 - SFY07	$ 3,218,001.77	$ 1,872,146.26	$ 2,337,164.39	$ 7,427,312.41
DY06 - SFY08	$ 3,497,726.26	$ 3,532,895.73	$ 2,473,621.93	$ 9,504,243.92
DY07 - SFY09	$ 4,211,602.23	$ 3,210,351.13	$ 1,460,182.27	$ 8,882,135.63
DY08 - SFY10	$ 4,185,263.43	$ 3,716,486.47	$ 1,020,142.91	$ 8,921,892.81
DY09 - SFY11	$ 4,569,218.75	$ 3,342,886.54	$ 956,816.93	$ 8,868,922.22
DY10 - SFY12	$ 6,483,482.44	$ 3,313,293.34	$ 1,146,963.16	$ 10,943,738.94
Grand Total	**$ 35,986,336.61**	**$ 27,896,801.00**	**$ 19,080,272.53**	**$ 82,963,410.14**

Comparison of actual experience to our projections

Measurements of changes in health status by having members complete more than one survey. Measurements will include general health, cognitive function, mental health and overall well being. The survey used is the MOS-HIV, a nationally published HIV Health Status survey published by the Medical Outcomes Trust.

This survey is no longer used. We will be using the MaineCare satisfaction survey unless a more suitable survey is found.

Overall cost neutrality

Measure and analyze outcome data for trends of disease progression and health status stability. Compare to the costs associated with members with advanced disease states to prove that inventions are cost neutral.

Conclusion: RECAP

The Maine HIV/AIDS 1115 Demonstration Waiver has become a vital part of HIV care in Maine as it provides healthcare coverage for approximately one-half of known HIV infected Maine residents.

The Department of Health and Human Services will review trends associated with demographics, waiver enrollment, disease status and cost trends. The goal of this demonstration is to delay, prevent, or reverse the progress of HIV/AIDS by providing comprehensive and affordable access to treatment in the early stages of illness.

Plans for Evaluation Activities during the Extension Period

A draft of the evaluation report which measures the effectiveness of Maine's Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS is due to CMS on September 1, 2013. We plan to continue with data collection and analysis supplemental to the draft evaluation design provided on July 19, 2013. We will coordinate with the Director of the Office of Continuous Quality Improvement, who will review the evaluation report in order to determine whether the report sufficiently evaluates the impact of the waiver, and is statistically objective and accurate. We will work with Ryan White/ADAP to obtain additional data. We will continue to collect relevant data for current and subsequent demonstration years. A final evaluation report is due to CMS on February 28, 2014 which will chronicle the waiver from its start to the end of Demonstration Year 11 (State Fiscal Year 2013).